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ABSTRACT

This report of a World Health Organization Expert Committee discusses the importance of ensuring healthy psychosocial development and the prevention and treatment of mental health problems in children and stresses the inadequacy of existing services in most countries. The first section reviews the current world situation in child mental health, emphasizing: (1) population characteristics; (2) epidemiological and developmental features; and (3) patterns of existing services. The second section examines possibilities for action, specifically: principles of intervention; preventive and treatment measures; research implications; service provisions and personnel development; and planning and coordination. The final section offers recommendations to those who formulate national policies, deploy financial resources and personnel, and develop services in the following areas: prevention and treatment of childhood mental disorders and fostering of healthy psychosocial development; development of etiological knowledge; program planning and coordination; training of child mental health personnel. WHO's role in child mental health programs is discussed. (SE)

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Child mental health and psychosocial development

Report of a
WHO Expert Committee

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CONTENTS

Page

Introduction 9

Part I. THE CURRENT SITUATION

1. Population characteristics and secular trends 10

2. Epidemiological and developmental features 11

2.1 Assessment, diagnosis, and classification 13

2.2 Prevalence of mental health problems in children 14

2.3 Course of mental disorders in children 16

2.4 Factors influencing psychosocial development 18

2.4.1 Biological factors 18
2.4.2 Cognitive factors 19
2.4.3 Ecological and social factors 20
2.4.4 Patterns of upbringing 21
2.4.5 Ameliorating influences and factors leading to positive development 24

3. Patterns of existing services 26

3.1 Traditional methods 26

3.2 Nonpsychiatric services for disturbed and retarded children 26

3.2.1 Health services 27
3.2.2 Educational services 28
3.2.3 Social welfare services 28

3.3 Psychiatric services for children 29

3.4 Existing primary prevention 30

Part II. POSSIBILITIES FOR ACTION

1. Principles of intervention 31

2. Preventive measures 32

2.1 Preventive measures immediately applicable 34

2.1.1 General health measures 34
2.1.2 Social welfare measures 35

2.2 Medium-term interventions 38

2.2.1 Schools and day-care facilities 38
2.2.2 Patterns of child care in residential institutions 39

Page

2.2.3 Urbanization and industrialization 40
2.2.4 Protective influences 41

2.3 Other possibilities of prevention 41
2.3.1 Parental mental disorder 41
2.3.2 Family discord 42
2.3.3 Parenting deficiencies 42

3. Treatment measures 42

3.1 Measures found to be effective in evaluative studies 43
3.1.1 Behavioural methods 43
3.1.2 Focused short-term counselling 43
3.1.3 Drugs 44

3.2 Probably effective but more costly measures 44
3.2.1 Hospital treatment 44
3.2.2 Special educational or residential services 45
3.2.3 Specialized psychotherapy 45
3.3 Measures found ineffective when tested in some countries 46
3.4 Measures that have not been evaluated and cannot be recommended. 46

4. Research implications and priorities 46

4.1 Evaluation of preventive and therapeutic interventions 47
4.2 Development of measures 47
4.3 Comparative epidemiology 48

5. Service provision and personnel development 49

5.1 A national programme of training and education 50
5.2 Service structure 53
5.3 Evaluation and monitoring 54

6. Planning and coordination 55
6.1 Constraints in planning 55
6.2 Steps to facilitate planning 58
6.2.1 A national policy 58
6.2.2 Mechanisms for coordination 59
6.2.3 Centres for training and research 60

Part III. RECOMMENDATIONS

1. Introduction 61

2. Recommendations on the prevention of childhood mental disorder and the fostering of healthy psychosocial development. 63

Page

3. Recommendations on the treatment of mental disorders in children. . . . 64

4. Recommendations on the development of knowledge concerning the magnitude, nature, and causes of mental health problems in children in various countries 65

5. Recommendations on the planning and coordination of programmes. . 66

6. Recommendations on the training of child mental health personnel. . . 67

7. WHO's role in programmes concerned with child mental health and psychosocial development 67

7.1 Technical cooperation with countries 68

7.2 Transfer of information 69

7.3 Coordination with international agencies 70

8. Conclusion 70

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Geneva, 9–15 November 1976

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CHILD MENTAL HEALTH AND PSYCHOSOCIAL DEVELOPMENT

Seventeenth Report of the WHO Expert Committee on Mental Health

INTRODUCTION

The WHO Expert Committee on Mental Health met in Geneva from 9 to 15 November 1976 to discuss child mental health and psychosocial development. The meeting was opened by Dr T. A. Lambo, Deputy Director-General, who welcomed members of the Committee and representatives of nongovernmental organizations on behalf of the Director-General. Dr Lambo pointed out that the mental health needs of children, who comprise a very large proportion of the population of the world, received too little emphasis in programmes concerned with health and wellbeing. Knowledge about psychosocial development and about child mental health is only rarely applied, an omission that is particularly dangerous in times of rapid socioeconomic and political change. At the same time the effectiveness of programmes is hindered by important gaps in knowledge, although the research technology necessary to obtain such information has become available.

It was for these reasons that the Expert Committee was asked firstly to review available knowledge and possibilities for its application in health and social welfare programmes and secondly to identify whatever additional information may be necessary and the methods of obtaining it. The main focus of these considerations was the improvement of the mental health and psychosocial development of children rather than a detailed study of topics covered in previous meetings, such as mental retardation, juvenile delinquency, and epilepsy.

Dr Lambo called the attention of the Committee to the fact that WHO's essential functions were cooperation with countries and the transfer of information necessary to establish effective programmes. He urged the Committee to be bold in their deliberations, to think of health and development rather than disease and to pay particular attention to the needs of children in developing countries. Efforts in this area were of great social relevance, and proposals for programme activities must be formulated in the complex framework of interrelations of child health, psychosocial factors, socioeconomic settings, and political reality.

PART I

THE CURRENT SITUATION

1. POPULATION CHARACTERISTICS AND SECULAR TRENDS

There are 1.3 billion children under the age of 15 years in the world—about a third of the world's total population. Approximately 83% live in developing countries, where they form a high proportion (a recent estimate suggested 40%) of the total population. By contrast, not only do developed countries have smaller overall numbers of children but the proportion of children (approximately 25%) is also smaller.

There is also a sixfold difference in infant mortality rates between developed and developing countries. Indeed, the extreme figures show a much greater difference since they range from one infant in six dying in Africa compared to approximately 1.1 per 100 in some industrial countries. In all countries the socioeconomic level is the most important variable affecting infant mortality. Mortality rates in older children also vary according to the state of economic development. For example, the mortality rate in Mexico in 1972 for children in the age range 1–4 years was 843 per 100 000 total population compared to 79 per 100 000 in the Netherlands—a tenfold difference.

Reliable morbidity data are very difficult to come by, but it can reasonably be assumed that the main killers (infectious diseases and malnutrition) are also the main direct or indirect causes of morbidity. Reliable figures are, however, available for the proportions of people with food supplies inadequate in protein and energy, and it is a striking phenomenon that, while in the developed countries 3% of the population are below an acceptable lower limit for food intake, the average figure for developing countries is 25%.

Urbanization is proceeding rapidly, particularly in developing countries. Whereas 25 years ago the proportion of the population living in big cities was less than 30%, it is predicted that by 1990 half the world's population will live in urban areas. Patterns of movement from rural areas to large cities vary, but in general the movement is motivated by the wish for employment. Consequently it often happens that the father leaves the family behind in the country in order to look for work in the town. Living conditions in large cities are often highly unsatisfactory, and many city dwellers now live in large insanitary

shanty towns on the edge of enormous urban conurbations with inadequate transport, housing, education, and health and welfare services. Migrant families have to cope not only with this poor environment but with the lack of support from close kin and friends and from traditional beliefs and practices.

Although figures are not readily available, it is likely that family breakdown in urban areas in developing countries is increasing. Certainly there are rising divorce rates in many developed countries, and consequently increasing numbers of children are growing up in broken homes. Further, the illegitimate-birth rate is rising in many developed and developing countries, and the children concerned (often born to very young mothers) are now, in some parts of the world, less commonly given up for adoption. Consequently a larger number of children are being raised in single-parent families and situations of social disadvantage. In developing countries the problem is made worse by the large numbers of children abandoned in city slums.

Employment of women is increasing in many parts of the world and this has resulted in a larger proportion of children experiencing substitute care during the day. In most cases this will take place with extended kin, but there is also increasing use of child minders and day-care centres.

Finally, in this brief review of changing influences in the lives of children throughout the world, the effects of increasing numbers of children attending school must be mentioned. Developing countries vary considerably in the age limits of compulsory schooling, but in virtually all of them some advance has been made and levels of literacy are rising. Despite the undoubted advantages of literacy in improving living standards and quality of life, the attempt to attain literacy inevitably involves failure for a certain number of individuals. The psychosocial consequences of this phenomenon will be discussed later in the report.

2. EPIDEMIOLOGICAL AND DEVELOPMENTAL FEATURES

Well established guides to children's development are available for psychomotor development (e.g., age of sitting without support, age of walking, etc.) and language acquisition (e.g., age of first meaningful words, age of first use of phrase speech, etc.). Similar guidelines have yet to be established for psychosocial development, but knowledge is available on some of the key issues and stages. Thus, for example, in the second half of the first year, infants usually develop selective attachments or bonds to other people (generally most strongly to the mother).

It appears that intense interactions with a sensitive and responsive person who is regularly present and available to provide comfort at times of fatigue, stress, or illness is most likely to facilitate this important early stage of development. Lack of contact between parent and infant in the neonatal period may impede optimal parenting in later months.

As the toddler grows older he learns to feel secure in an increasing range of situations and to maintain bonds when apart from his parents. He begins to play alongside, and then with, other children, learning how to cooperate with them and join in group activities. During middle and later childhood, friendships deepen and become more lasting. Family influences continue to be important throughout development, but peer groups, schools, and community influences increasingly serve to shape and modify psychosocial development.

The basic requirements for normal psychosocial development (in addition to an intact nervous system) include a warm and accepting environment with stable parents or parent substitutes who are sensitive to the child's emotional needs and who provide appropriate conversational interchange and opportunities for play and consistent discipline, supervision, and support. In addition, there must be the possibility of increasing autonomy and independence, adequate interaction with other children and adults outside the home, and suitable learning opportunities.

Obviously, many children do not experience these conditions, and later in this report the various hazards and stresses that predispose to mental health problems and difficulties in psychosocial development are discussed. First, however, it is necessary to consider the nature and prevalence of these problems.

Mental health problems in childhood have two important characteristics: they represent, for the most part, quantitative deviations from healthy or normal development, and many of their manifestations can be seen as responses to specific situations.

The majority of children experience emotional or behavioural difficulties (e.g., fears, or disturbances to sleep or to eating patterns) at some time or other during their development. Most of these problems are of a transient nature and more recent studies suggest that the significance attached in the past to such " neurotic traits " has been exaggerated. Some children, however, have problems which, though not very different in kind from difficulties found frequently in the general population of children, do differ in the degree of severity and the extent to which they impede overall psychosocial development—i.e., they are multiple, persistent, and socially handicapping. These may be termed mental disorders.

Often children show severe difficulties in one situation but not in another ; for example, they may manifest disturbed behaviour at school but not at home, or vice versa. Such observations indicate that childhood mental health problems are linked, perhaps in a more direct way than in other age periods, to the children's interaction with their environment and that understanding of this environment is particularly important in evaluating child mental health.

A relatively small proportion of mental disorders in childhood do constitute conditions qualitatively different from normal development (autism and childhood psychosis are two examples), but this fact does not detract from the general conclusion that often no clear-cut distinction can be made between mental disorders and disturbed psychosocial development in children.

2.1 Assessment, diagnosis, and classification

In the past, one of the barriers to effective communication in the mental health field, both between and within countries, has been the lack of agreed methods of evaluating and differentiating between the varieties of mental health problems. This situation has made it difficult to compare findings obtained in different parts of the world and to exchange potentially useful information and experience. However, considerable improvements have occurred in recent years, and WHO-coordinated work has played an important role in the development of a common language among mental health workers. In the field of child mental health such advances have been achieved in the development of assessment tools and classification.

Screening questionnaires of demonstrated reliability and validity are now available to identify children likely to have mental health problems. While such instruments have mostly been devised and evaluated in developed countries, several studies in which these tools have been applied in developing countries indicate their probable utility in different sociocultural settings. Techniques for standardizing personal interview methods have also been developed, and it is now possible to train interviewers who are not qualified psychiatrists in their use. These new developments have made it possible to carry out epidemiological studies to compare the frequency, course, and social accompaniments of childrens' mental health problems in different cultures and countries.

In the field of classification, a new multi-axial scheme for children has been developed and tested that allows a more systematic recording of information relevant to the principal elements of diagnosis—i.e., the

clinical psychiatric syndrome, intellectual level, specific delays in development, underlying or associated medical conditions, and disturbed psychosocial environment.[1] The encouraging experience with this multiaxial scheme led to the introduction of a number of new categories specifically for children's mental disorders in the ninth revision of the International Classification of Diseases.[2] A glossary included in the ninth revision providing definitions of classification categories and instructions for the use of codings is another recent development contributing to greater comparability of information on childhood mental disorders.

In spite of these achievements, further work will be necessary to facilitate the assessment of child mental health problems and the planning and delivery of services. It is necessary to develop simple and reliable assessment tools that could be used by nonspecialist workers in a wide range of services (educational, social, forensic, paediatric, etc.) and to develop techniques for evaluating family functioning and children's psychosocial environment in different sociocultural settings.

There is some concern that the identification of mental disorders in children might be disadvantageous to them because of stigma and negative discrimination resulting from labelling. This does sometimes arise when labels are used as mechanical guides to administrative action or when diagnoses are used as permanent labels that continue in existence after the disorders have remitted. However, these are clear misuses that should be strongly discouraged. Assessment should always be used as the means of initiating appropriate treatment or as a guide to needed preventive services. It is the responsibility of those who use diagnostic terms to ensure that they are understood and acted upon in ways that benefit individual children. Labelling can and should result in advantage if used with care, discrimination, and concern.

2.2 Prevalence of mental health problems in children

Surveys of general populations show that the prevalence of persistent and socially handicapping mental health problems among children aged 3–15 years in developed countries is about 5–15%. More limited data from developing countries suggest a roughly similar rate. Of course, there cannot be an exact prevalence figure for mental disorders in child-

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[1] RUTTER, M., ET AL. *A multi-axial classification of child psychiatric disorders*, Geneva, World Health Organization, 1975.

[2] *Manual of the international statistical classification of diseases, injuries, and causes of death, 9th revision*. Geneva, World Health Organization, 1977.

hood. Firstly, as already mentioned, most represent departures from psychosocial normality rather than specific diseases. As a consequence, prevalence figures will necessarily be affected by the threshold or cut-off point used in making a diagnosis. Secondly, disorders vary in frequency according to both developmental and social circumstances. Thus, mental health problems are more common in boys than in girls, are somewhat more frequent in adolescence than in earlier childhood, and at least in developed countries more frequent among children living in inner city areas than in small towns or rural areas. Nevertheless, it can be concluded that mental health problems in childhood are sufficiently common to constitute a major concern in the planning of health services and to make it impracticable for them to be dealt with mainly by specialist services. Moreover, the nature of the problems makes it desirable to plan therapeutic services in a community setting within the context of normal, as well as abnormal, psychosocial development.

Three groups of problems particularly affect prevalence rates: emotional disorders, conduct disorders, and impairments of delays in the development of normal functions. Emotional disorders (e.g., fears, anxiety, depression, obsessions, hypochondriasis) occur with the same frequency in boys and girls, while conduct disorders (in which poor peer relationships and destructiveness constitute the main features) are significantly more common in boys. Particularly in younger children, a subgroup can be identified in which overactivity correlates with a serious lack of attention paid to the child. Impairments or delays in development are markedly more common in boys than in girls. Developmental disorders of speech and language occur in some 1–5% of children (rate varying according to severity); regular bedwetting is present in about 3% of children at age of the of 10; and reading retardation in children of normal intelligence is found to be present in about 3–10% of children.

Relatively little is known about the prevalence of mental health problems in children under 3 years of age, but there is evidence that emotional disorders and developmental delays do occur in very young children. In many cases the problems in this age group concern parent–child interaction rather than the behaviour of the child. The most severe example of this is " child battering " (or " non-accidental injury "). In some developed countries the available figures indicate that, up to the age of 4 years, approximately one child per thousand suffers serious injury by parents each year, and about one in ten of the injuries proves fatal. Data are not available from developing countries, nor are there reliable figures available from any country for lesser disorders of parent–child interaction.

Psychotic disorders are far less prevalent in childhood than they are later in life. Autism occurs in about 3 or 4 children out of every 10 000, and functional psychoses such as schizophrenia or manic-depressive disorder are quite rare before adolescence.

Severe mental retardation affects about 4 children per 1000 and mild retardation some 30 per 1000. Despite a degree of overlap these disorders add to the number of children with mental health problems. However, they are not specifically discussed for reasons given in the introduction.

In discussing the frequency of mental health problems in children, it is important to mention other groups of disorders, including epilepsy, organic brain syndromes, sensory impairments, communicable diseases, and systemic physical disorders. Not only are they important problems in their own right but they may also occur in association with other mental health problems in children and aggravate their course and consequences. Their public health importance is particularly great since in addition to being widely prevalent, they are amenable to primary prevention through many of the measures discussed elsewhere in this report (e.g., better obstetric care, immunization, and accident prevention).

2.3 Course of mental disorders in children

In so far as most mental disorders in childhood constitute variations from normal psychosocial development rather than disease entities, it might be thought that they are of little concern and need not draw on limited service resources. However, this would be a seriously mistaken view. Not only are such disorders a source of considerable suffering to the child, but they are also associated with serious social problems and may be forerunners of serious psychiatric and social difficulties in adult life.

Emotional disorders in children have a relatively good prognosis, but nevertheless in over one-third of the cases they last at least 3 years, and a proportion of these children show neurotic or depressive conditions in adult life. Conduct disorders tend to run a chronic course and in many cases become personality disorders in adulthood. Follow-up studies show that children with such disorders are liable to have serious difficulties in their social functioning as adults, and often have persisting mental abnormalities. Children with the hyperkinetic syndrome also have a rather poor outlook and, although most cease to be grossly overactive, serious social and educational difficulties frequently continue. In adult life, many of them have personality disorders and a few become psychotic.

Autism is usually associated with handicaps that persist in some form throughout life. However, the prognosis is greatly influenced by whether or not there is associated mental retardation. Studies in developed countries indicate that about half the autistic children of normal, non-verbal intelligence eventually hold regular jobs in adult life. In contrast, virtually all severely retarded autistic children remain dependent and in need of continuous supervision ; many are placed in long-term hospital care.

The great majority of children with specific delays in speech or language talk normally by middle or later childhood. However, many of these children go on to have serious difficulties in reading and spelling. In some cases these are associated with emotional or conduct disorders. Although most individuals with mild mental retardation have scholastic difficulties in childhood, the great majority hold regular jobs in adulthood and rear ordinary families. On the other hand, although they can be taught many useful skills, severely retarded individuals usually remain dependent and very few of them become gainfully employed or produce offspring. Short-term follow-up studies of children who have suffered non-accidental injury suggest that a high proportion have learning and behaviour problems at school. The same is probably true of less severe disturbances of early parent–child relationships.

For health service planning it would be helpful to have information not only on the course of psychosocial problems but also on the course of normal psychosocial development and on the extent to which psychosocial difficulties are likely to recur in the next and succeeding generations. Studies in developed countries have shown important links between childhood experiences and behaviour as parents in later life. Individuals who suffer rejection and discord during their childhood are more likely when adult to have both marital problems and difficulties in bringing up their own children. A background of seriously abnormal upbringing is often seen in the case of parents who deliberately injure or grossly neglect their offspring. The two other groups in whom intergenerational continuities are most evident are individuals with conduct and personality disorders and those with mild mental retardation. In both cases there is a higher risk of similar disorders in their children than is the case in the general population.

Although these data provide useful information, it is crucial to note that discontinuities are far more frequent than continuities. Thus, about five out of six children reared by mentally retarded parents are of normal intelligence. Similarly, most individuals from unhappy homes subsequently have stable marriages. Finally, it has been found that conti-

nuities over three generations are much less frequent than those over two.

2.4 Factors influencing psychosocial development

There is extensive literature on causes and correlates of mental disorder in childhood and on factors thought to influence psychosocial development. In summarizing and interpreting this literature several important points must be made. Firstly, there is the need to differentiate statistical associations (which may be incidental) from causal processes. Secondly, the factors responsible for the occurrence of mental health problems must be distinguished from those that influence the course of the disorder. In some cases they are the same, but in others they are quite different ; for example, the circumstances that predispose people to start taking drugs are probably not the same as those that lead to the development of drug dependence. Thirdly, it must be recognized that causation involves several quite different questions; for example, the reasons why an individual has a mental health problem may be very different from the reasons for the prevalence of mental health problems in the general population. Thus, economic and sociopolitical issues largely determine the levels of unemployment in a country but personal variables (age, physical incapacity, lack of skill, etc.) are important in individual cases of unemployment. Fourthly, it is necessary to determine whether a variable has the same effect in all cultures or whether its impact is culture-specific.

2.4.1 *Biological factors*

Individual differences between children are observed from birth onwards and these differences influence psychosocial development. They comprise factors as diverse as the child's temperamental characteristics, sex, physical appearance, and rate of development. Of course, temperament is greatly influenced by the child's experiences and opportunities, but biological factors are also important. Whereas very few mental disorders in childhood are inherited as such, genetic factors do play a role through their influence on personality and on vulnerability to environmental stress.

In all societies in which it has been studied, brain damage or dysfunction (such as indicated by cerebral palsy or epilepsy) has been found greatly to increase the risk of mental health problems. There is good evidence that brain dysfunction is important in its own right as a cause of mental illness, quite apart from the effects of psychosocial stress or

disadvantage with which it may be associated and the intellectual impairment or specific cognitive deficits that may follow it. In addition, it is well known that the great majority of cases of severe mental retardation are a consequence of brain disease or damage. Organic brain dysfunction also plays a part in the genesis of some cases of mild mental retardation, but psychosocial influences are in this instance usually more important.

In developed countries it has been found that chronic physical handicaps are associated with an increased rate of mental health problems. However, the effect is much less than in the case of brain damage, and the association probably reflects indirect influences mediated by such variables as lack of sensory stimulation, emotional deprivation, lowered self-esteem, restrictions on physical activities, negative community attitudes, and stresses associated with medical treatment (e.g., recurrent hospital admission and side-effects of drugs).

Less is known about the importance of physical disorders as influences on psychosocial functioning of children in developing countries. Certainly, the rate of physical disorders in children referred for treatment of mental health problems is high. However it is uncertain how far this simply reflects a higher prevalence of physical illnesses in the general population and how far it implies either a different pattern of associations or the greater influence of chronic physical disorders on psychosocial development.

2.4.2 *Cognitive factors*

In all literate societies in which the matter has been investigated, emotional and conduct problems have been found to be relatively common in both mentally retarded children and children with specific disorders of learning or language development. It is probable that several different causal processes are involved in these associations. Firstly, the mental disorders may stem from the same basic factors that led to the cognitive impairment—i.e., the brain damage or the psychosocial deprivation. Secondly, the risk of poor mental health may stem in part from the experience of school failure. This is suggested both by the pattern of correlations and also by the association between cognitive impairment and mental disorder, which tends to be more marked in relation to children's behaviour at school than at home. In so far as the second mechanism is valid, it implies that the risk of poor mental health need not be inevitable. Alterations in the school environment to aid both the acceptance and functioning of the low-achieving child might bring benefits.

2.4.3 *Ecological and social factors*[1]

It is clear from all the evidence relating to ecological and social factors that careful attention must be paid to the mental health effects of sociopolitical changes.

It has been found in developed countries that mental health problems in children are more common among those living in inner cities than among those in towns or rural areas. It appears that this is due in large part to the higher rates of family difficulties in inner city areas. Children's psychosocial functioning can be more frequently impaired in the cities because more children live in discordant unhappy homes or have depressed or deviant parents. However, relatively little is known about the specific features of city life that have this adverse effect on family functioning. It is not urbanization *per se* because many medium-sized towns have rates of disorder comparable to those in rural areas ; nor is it a function of population density or of industrialization, because industrial areas may have relatively low rates of psychosocial disorder. There is an urgent need to identify the features of city life that hamper family functioning and predispose to mental disorder, as knowledge on this matter carries the possibility of instituting effective preventive measures.

The data on mental health aspects of housing are complex and difficult to interpret. While good housing is obviously desirable, epidemiological studies indicate that neither the type of housing in terms of house versus apartment nor the extent of household facilities (e.g., bathroom, kitchen) has any clear association with rates of mental disorders. However, there is some association of mental health problems with multiple-occupancy dwellings and serious overcrowding. Although systematic data are lacking it is highly likely that extremely poor conditions of housing (as in shanty towns) also predispose to mental ill health. The transfer of families to housing with better physical facilities has no consistent effect on mental health. If the transfer involves disruption of ties with family or friends it may actually predispose to mental disorder—at least in parents. It can be concluded that housing is of some importance for psychosocial functioning but that its relevance is likely to lie less in the physical characteristics, space, and equipment than in the social qualities of the environment provided. Data are lacking on the crucial psychosocial features of housing design but they are likely to include the provision of privacy and personal space, the maintenance of

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[1] See also : MEYER, E. E. & SAINSBURY, P., ED. *Promoting health in the human environment*, Geneva, World Health Organization, 1975.

links with kin and friends, community cohesion, and the opportunity for supervised play.

Although poverty and low socioeconomic status are associated with higher rates and more disabling consequences of various mental disorders in adults, the association between these factors and the occurrence of mental health problems in children is less clear-cut and may vary between different types of community. Since poverty is often the background for a whole cluster of psychosocial phenomena (e.g., broken homes, loose family ties, educational disadvantage, increased rates of delinquency and crime, illegitimate births) it is likely that its effects on child mental health are mediated through those factors rather than through income levels only. While the evidence is not complete, it appears that when poverty or low social status lead to family disorganization and disruption, then there are adverse effects on the mental health and psychosocial development of children. If the relief of poverty facilitates family functioning, the mental health benefits of such measures may be substantial. On the other hand, raising the level of income alone does not automatically have this beneficial effect, and there is ample evidence from many developed countries that increasing affluence does not reduce the extent and frequency of mental health problems. Indeed, children in developed countries have considerable mental health problems in spite of prosperity.

Migration is not necessarily associated with any increase in mental health problems, and population movement may sometimes involve psychosocial benefits. Nevertheless, in many countries migrants are at a disadvantage and there are mental health risks associated with major psychosocial change. The variables involved have not been well studied but it seems likely that the risks stem in part from the break-up of families and tribal or other community support systems, the lack of adequate child-care facilities which follows from this break-up, the alienation of migrants in the community or discrimination against them, and the very poor living conditions in the slums and shanty towns in which many migrants have to live.

2.4.4 *Patterns of upbringing*

It has been well demonstrated in studies in both developing and developed nations that variations in the psychosocial development of children are strongly associated with qualities of parent–child interaction. In particular, it is known that when children are reared in homes where there

is a lack of conversational interchange, where parents do not interact positively with their children, and where there is a lack of play opportunities, the development of language, intelligence, and scholastic skills is likely to be impaired. Similar associations have been found in children reared in institutions and it may be concluded that it is a causal connection. This pattern of inadequate parent–child interaction is sometimes discussed in terms of " lack of stimulation ". Whereas it is true that children need stimulation, both experimental and clinical studies show that it is active experiences and interchange that matter. Parents need to be helped to understand that it is not enough to do things *to* their children ; they must do things *with* them. Verbal stimulation is provided by talking with the child and not by turning up the volume of the radio. Similarly, it is helpful to provide toys, but children may also need to be encouraged to create their own play opportunities. There is good evidence from numerous studies in a variety of societies that there is a very substantially increased rate of mental health problems in children who are unwanted or who experience rejection, hostility, or serious family discord.

At one time it was thought that even temporary separation of a child from his parents created a serious psychosocial hazard. It was on this basis that previous committees have argued the dangers of mothers going out to work or of the child receiving day care. It is now clear that these arguments were to some extent mistaken. Children *do* need continuous relationships with a small number of parent figures but brief separations need not necessarily disrupt these relationships. Good-quality day-care and a working mother are both compatible with secure parent–child relationships.

A separate issue arises with respect to separations due to admission to an institution (e.g., residential nurseries or hospitals) since such admissions are likely to involve mental health risks for the child. This is particularly true if the admission is due to family discord since these children are least able to cope with such separation. The quality of care in such cases is crucial. On the other hand, children from severely deprived homes may benefit from removal to a superior institutional environment.

Continuity of relationships to parent figures is especially important in the first few years of life. It has been found that the children most at risk are those who experience multiple changes of parent figures or who are reared in institutions with many attendants who have no special responsibility for individual children. Thus, there are dangers in delaying the adoption of children abandoned by their parents, in taking children

in and out of institutional or foster care, and in an impersonal institutional upbringing.

Studies in many different countries on parental deviance have shown that children brought up by criminal or mentally disordered parents show an increased rate of mental health problems. While genetic factors may play some part in this association, it is clear that the hazards are in considerable part a function of the family discord and disturbed patterns of child-rearing that often accompany parental mental disorder.

In the past, great attention has been paid to certain patterns of child care such as timing of weaning and toilet-training, methods of discipline, and the like. It is now clear that these concerns were misplaced. Within quite broad limits the timing and mechanics of these aspects of child care are of little psychosocial concern. On the other hand, the quality of care (in terms of sensitivity and responsiveness to the child's needs), the relationship between the child and those who look after him, and the consistency and efficiency of child-rearing methods are of some importance. Markedly inconsistent patterns of punishment, repressive or brutal handling, and a lack of concern all increase the risk of mental health problems.

At least in developed countries, illegitimate children, children reared by very young mothers, and those brought up in nuclear families with very many children are also more likely to show problems in psychosocial development. The mechanisms underlying these associations are not well understood. That such families are often poor, that the children are often unwanted, and that there are greater difficulties in child-rearing when parents have to divide their time and resources among many children may be pertinent factors.

Numerous investigations have shown that very young children frequently experience distress and disturbances as a result of hospital admission. However, it has also been shown that the mental health risks can be markedly reduced by improved hospital conditions and by the parents spending time with the child in hospital (or by one being admitted with the child). On the whole, there are few long-term risks associated with a single hospital admission, but it has recently been shown that mental disorders in later childhood and adolescence are more frequent in children repeatedly admitted to hospital.

It has already been noted that day-care for young children need not interfere with harmonious and secure parent–child relationships. It should be added that good-quality day-care can have positive psychosocial benefits, particularly in the case of children from poor or disordered homes. However, the effects have been most studied with respect to

language and cognitive development, and very little is known about the emotional or social benefits and deficits. Obviously much is likely to depend on the quality of care provided, but so far there is no good evidence to suggest that either day-care or preschool education has such a lasting benefit to children's mental health that it could be advocated on these grounds alone.

Children reared in institutions often show intellectual impairment as they grow up. There is now sound evidence to show that this need not be the case. Children's intellectual development is influenced by the quality of experiences in institutions (as it is in families) but institutional care as such need not be cognitively damaging. On the other hand, it has proved more difficult to provide in institutions all that children need for optimal social and emotional development. Reliable information is lacking but probably the mental health risks mainly lie in the very large number of staff looking after each child and the lack of any parent surrogate with an emotional commitment to the child.

Studies in developed countries have shown that schools can have an important impact on children's psychosocial development. Rates of mental disorder in some schools may be several times as great as those in others. Longitudinal studies have indicated that this is an effect of the school environment on the child and not just an artefact of selective intake. It seems clear that the influence lies primarily in the ethos or qualities of the school as a social institution and in the nature of staff–child interaction rather than in physical resources, size of school, and the like. However, further research is needed to identify precisely what has to be done to make a school a place that facilitates and fosters optimal psychosocial development.

2.4.5 *Ameliorating influences and factors leading to positive development*

The knowledge discussed thus far relates to factors that tend to damage psychosocial development or predispose to mental disorder. Information on these stresses or disadvantages is, of course, essential to planning preventive and therapeutic services. However, it is at least as important (if not more so) to pay attention to influences that facilitate normal development and to circumstances that enable children to develop normally in spite of stress, deprivation, and social disadvantage. It is clear from research findings that there are very few psychosocial hazards that cause damage to all childen ; usually only some children succumb. We need to ask what it is that enables children to overcome disadvantage or escape stress and deprivation.

The first answer is that the supposed stress may not have been a stress at all. Mention has already been made of the mistaken notions in the past that children are inevitably damaged by day-care, separations, or their mother going out to work. It is all too easy to mistake associations for causes and to base interventions on wrong ideas about psychosocial processes.

However, another answer is that there may be a number of compensating or positive factors that make it more likely that children will come through stressful experiences unscathed. There has been little research on this matter, and most findings require reflection before they can safely be used as a basis for policy. Therefore it would be highly beneficial if priority were given to research in this area.

The possible protective factors include the following:

(1) Sex. For reasons that are ill understood (but which are probably both biological and social), girls appear less susceptible to most psychosocial stresses in childhood.

(2) Temperament. Children with an adaptable temperament are generally more resilient in the face of deprivation and disdavantage.

(3) Isolated nature of the stress. It appears that surprisingly little damage is done by even chronic stresses provided they occur in isolation (e.g., parental mental disorder in harmonious homes without social disadvantage). However, multiple stresses interact to potentiate the psychosocial damage.

(4) Coping skills. One study found that children who were used to brief happy separation experiences (such as staying with friends or relatives) coped better with the stress of hospital admission. Presumably, children can acquire coping skills relevant to other stresses.

(5) A good relationship with one parent. It has been shown that the risks to mental health that stem from an upbringing in a discordant, unhappy home are appreciably reduced if the child is able to maintain a good relationship with one parent. It is possible although not yet demonstrated that good relationships with other relatives in an extended family might have a similar beneficial effect.

(6) Success or good experiences outside the home. It seems that good schooling can do something to mitigate the effects of a poor home environment.

(7) Improved family circumstances. When a child is reared in a disturbed, quarrelsome family there is a substantial risk to mental health. However, if family circumstances improve and the later years of childhood are spent in harmony the risk is appreciably reduced.

These findings clearly indicate that there is much potential for preventing mental health problems and that a major improvement in children's psychosocial development is possible through actions that are feasible in most countries.

3. PATTERNS OF EXISTING SERVICES

In developing countries the coverage of the population through existing services is unsatisfactory. In developed countries, although more services are provided, large gaps remain and services are often badly distributed.

3.1 Traditional methods

In many communities, particularly in rural areas in developing countries, some children's problems are tolerated and others are dealt with by traditional methods, often with the approval or help of the local community healer. When traditional methods have positive effects on psychosocial development, an attempt should be made to promote their use. Negative effects may include stigmatization, exclusion of the individual from the community, and untoward physical effects if harmful substances are given, for example, or if effective treatment is withheld.

However, because of industrialization and urbanization many people no longer rely on traditional methods. Although vestiges of such beliefs can often be seen in the urbanized family, there is an increasing tendency to seek help from health services. In developing countries, therefore, there is an increasing awareness of the importance of the provision of care by health professionals. In developed countries, although it is less clearly descernible, a similar trend can be noted.

3.2 Nonpsychiatric services for disturbed and retarded children

The pattern of delivery of mental health care differs from country to country, but in nearly all of them it would seem appropriate to divide these services according to the type of agency involved—health, education, or social welfare.

3.2.1 *Health services*

Within any given developing country there is considerable variation in the provision of health services generally, and rural areas, which contain 80% of the populations of many such countries, are particularly poorly served.

In developing countries paediatricians are often extremely few in number, and health services are usually provided by the public health nurse or by auxiliary workers. The public health nurse's time is usually fully taken up by measures for combating infection and malnutrition but, since hers is the advice most readily available, she is the person to whom families will turn for help with their childrens' mental health problems. This is also the case in some developed countries where the health visitor or child health nurse is likely to be the person outside the family most frequently consulted for such problems when they occur in the first two or three years of the child's life.

For all social classes in most developed countries, and for middle-class families in developing countries, the family doctor is the key nonpsychiatric professional. In some countries basic health care for the child is provided by the paediatrician, and there is an increasing tendency to recommend routine developmental assessments of young children's progress so that the detection of delay and deviation is less dependent on the parents. Many problems are missed when only the parents are relied on for their identification and reporting. Public health nurses and trained primary health care workers can be instructed to obtain information systematically from parents, and it has been shown that such procedures can result in successful identification of virtually all children with serious mental retardation and language delay. However, personal examination using special tests is necessary to identify most hearing and visual defects.

Routine examinations are also often carried out in school-age children through a school medical service, and problems of psychosocial development may come to light in these examinations. However, the superiority of expensive routine examinations by physicians over simple surveillance procedures carried out by parents and teachers under supervision is still a matter for debate.

More-specialized paediatric services existing in developed countries and in large cities in developing countries also cater for children with mental health problems. They are particularly concerned in diagnosing the underlying cause of mental retardation and in assessing and treating children whose disturbances have a somatic component.

3.2.2 *Educational services*

In developing countries, where it has often not been possible to provide even primary education for the total population, it is not surprising that very few services exist for children with special educational requirements, although the need for them is often recognized. There is also general recognition that teachers in ordinary schools should be trained to identify and handle many disturbances of psychosocial development.

Developed countries differ considerably in the specialized educational services available, but in most of them these services range from giving extra help or attention in the ordinary classroom to residential placement in a special school for children with emotional or behavioural problems. In the ordinary school, teachers may be given specific advice on how to deal with problem children in the classroom. Special classes for children with varying degrees of mental retardation, specific learning problems (such as reading retardation), and behavioural problems are also available in ordinary schools, and children may spend all or part of their time in such classes. Special day schools and boarding schools for retarded children and children with emotional and behavioural problems have been set up in some developed countries. Usually such schools are organized to deal with one type of handicap only—mild or moderate mental retardation, severe mental retardation, or emotional disturbance —but a minority deal with children with more than one handicap. Some schools for children with mild physical handicaps also take a proportion of mildly retarded or disturbed children particularly when the retardation is thought to be a result of a physical disability (e.g., deafness, cerebral palsy).

In addition to providing special classroom and school facilities, some educational authorities in developed countries have encouraged school counselling services, usually with the main aim of providing advice and guidance to older children and adolescents with psychosocial problems.

3.2.3 *Social welfare services*

In developing countries, systematic coverage of rural areas by social welfare departments has usually not been possible. Similarly, in big cities coverage by social service departments has been hampered by the massive difficulties of identifying and managing social problems. Social service departments or religious organizations are often responsible for orphanages for abandoned children, many of whom have serious emotional or developmental problems. Either these departments or

departments of justice are responsible for homes for delinquent children who have been removed from the care of their families by judicial procedures.

In developed countries a more comprehensive coverage of social problems has been possible, but even in these situations, particularly in big cities, many problems involving children never come to official notice. Social workers are, however, expected to be involved in all cases where parental care is inadequate. Initially they try to prevent family breakdown but if this is not possible they arrange substitute care in the form of adoption, fostering, or placement in a children's home. The residential care of delinquent children is also often the responsibility of social service departments, which in many cases have assessment units to consider the needs of such children before they are placed. Much of the work carried out on behalf of children by social workers in developed countries is of a crisis nature with resources inadequate to make a real contribution to prevention. In some areas special social service projects exist for particular purposes; among these may be mentioned services to cope with children with non-accidental injuries and walk-in clinics for adolescents with problems.

In all countries there is an acknowledged lack of training among non-mental-health professionals in childhood psychosocial development and mental health problems, even though these subjects represent a substantial part of the work of many of them.

3.3 Psychiatric services for children

The variation between developed and developing countries in the provision of psychiatric services for children is even greater than is the case with nonpsychiatric services. There is also considerable variation between and within developed countries.

Child psychiatrists are absent or extremely few in number in developing countries (there is, for example, only one child psychiatrist for every 12 million people in 23 countries in the Eastern Mediterranean Region), and most psychiatric care, if provided at all, is given by general psychiatrists or by neuropsychiatrists. Where child psychiatric facilities do exist, the attendance of a high proportion of children with physical problems has been noted. Outpatient facilities are rare, existing only in large cities, and inpatient facilities are generally lacking.

In developed countries the pattern of service delivery for disturbed children is usually on an outpatient basis. The social service or education

departments maintain child-guidance clinics, while general, paediatric, or psychiatric hospitals generally have departments devoted to child psychiatry. Regardless of where they are sited, these units tend to function in rather the same way and are usually staffed by a multidisciplinary team of psychiatrist, social worker, and psychologist. Siting may, however, affect the type of child referred in that clinics administered by the education department are more likely to see school-age children with conduct disorders while units in paediatric hospitals will receive younger children with physical problems. The main treatment provided has traditionally been psychotherapy with children and case-work with mothers, but over the past decade there has been increasing emphasis on family therapy, brief focused individual psychotherapy, drugs, and behavioural methods. Staff working in such clinics are also placing more emphasis on consultative work within the community. There is, however, considerable variation in the type of service provided by individual units. Some facilities specialize in one or two of these treatment methods, but an increasing number are attempting to provide a variety of treatments that match the individual needs of the child and his family.

In developed countries children's psychiatric facilities other than the child-guidance clinics have expanded very considerably over the past 20 years although their distribution remains uneven. In many countries inpatient units and day-centres for children are now widespread, although such services for adolescents are often less easily available. The organization of facilities varies, some clinics being directed by doctors, others by psychologists, and others by a " management team ".

3.4 Existing primary prevention

Knowledge in the area of primary prevention of childhood mental health problems is limited, and no national programmes have yet been developed and evaluated. However, a number of special projects have been described—e.g., educational programmes on normal child psychosocial development for adolescents in schools and for mothers attending antenatal or postnatal clinics ; systematic follow-up of children born of high-risk pregnancies ; and various types of counselling including adolescent, genetic, and premarital counselling and advice on child-rearing practices. The mass media—newspapers, television, and radio—and child-rearing manuals have also been used to provide information on the upbringing of children, but this has not been done in any systematic way nor is the advice given always good.

PART II

POSSIBILITIES FOR ACTION

1. PRINCIPLES OF INTERVENTION

At a time when many developing countries are still struggling to deal with high death rates and high physical morbidity in children, a concern with psychosocial development and mental health problems might be thought to be a dispensable luxury. This is not the case. In the first place, different aspects of children's development should not be separated artificially but integrated into a holistic approach. Improvements in physical health will also aid psychosocial functioning. Thus, relief of malnutrition would alleviate the apathy and misery that so often accompanies serious malnourishment. Moreover, it has been found in developing countries that seriously impaired psychosocial functioning in families is a powerful indicator that children in these families have a high risk of malnutrition. Improved psychosocial functioning should reduce the likelihood of physical hazards.

In the second place, mental health problems deserve attention in their own right. Judged by the criteria of frequency, seriousness, socioeconomic consequences, and community concern, they merit an important place in health service planning. As we have seen, socially handicapping mental disorders afflict at least one child in twenty. They frequently last several years and some are accompanied by school failure and dropout, while a significant proportion persist into adult life with resulting dependence on services, family difficulties, and irregular employment.

Thirdly, unless steps are taken to prevent it from happening, the socioeconomic changes taking place in developing countries are likely to bring an increase in the psychosocial problems that are already so common in the major cities of industrial nations. Increasing prosperity will not necessarily aid psychosocial development. Efforts must be made to ensure that socioeconomic gains are brought about in ways that aid rather than impede functioning. Action is needed now or it may be too late.

However, it is not enough to know that the problem is serious. It is also necessary to ask whether there is any evidence that we know how to intervene successfully. Is there the knowledge on which to base prevention or treatment? A review of findings shows that there is. While understanding of intervention measures is still very incomplete

and little is known about the transference of measures from one cultural setting to another, there is a large body of knowledge already available that could be applied immediately. All efforts must be monitored and evaluated in order to learn from experience and to increase the effectiveness of interventions and studies should be undertaken to devise new and better forms of prevention and treatment. The following two sections describe prevention and treatment methods that are recommended by the Committee and the steps required to implement them.

In making recommendations, the Committee was acutely aware of the severe limitations of existing resources, but while there is an undoubted need to increase facilities and personnel, the use of cheap and simple measures is likely to prove very effective. The main need is to develop and improve existing services rather than to introduce costly new or specialized ones. There is also a need to increase community participation. Thus the main recommendations concern the improvement of maternal and child health services and of the social and educational facilities currently being used by children. Much useful prevention can be done by promoting healthy family functioning, by improving day-care facilities, by ensuring that schools foster psychosocial development, by utilizing the health education possibilities presented by service contacts with families and children, and by providing training so that all who deal with children are aware of their psychosocial needs.

While the means are now available to introduce effective intervention procedures, social conditions change and improvements in prevention and treatment methods are constantly being made. This means that evaluation should be an integral part of intervention programmes so that monitoring can guide the development and course of programme implementation. Evaluation should include both an assessment of the effectiveness of intervention in optimum circumstances and a determination of the feasibility and effectiveness of its application on a community-wide scale. Evaluation reports should include a clear specification of what was actually involved in the intervention so that the results may be of practical use in planning services.

2. PREVENTIVE MEASURES

The Committee strongly recommended that countries should take immediate action to implement preventive programmes based on the extensive existing knowledge about children's psychosocial development and about the factors that influence it. In planning such programmes certain key principles were identified.

(1) The main emphasis should be placed on the most prevalent mental health problems associated with serious impairments in psychosocial functioning. This means that, for the most part, preventive measures will not deal with psychoses (such as autism, schizophrenia, manic-depressive psychosis) both because they constitute a very small proportion of mental health problems in childhood and because knowledge is lacking on how to prevent them.

(2) Interventions should be based on empirical findings concerning those factors found to have causal influences on psychosocial development. These may be either factors that foster normal development (interventions being designed to increase their effect) or those that predispose to mental health problems (in which case interventions are designed to reduce their effect).

(3) With but a few exceptions, short-term change in a chronically depriving situation will rarely have long-term benefits. To be effective in influencing ultimate levels of development, either the interventions must involve a lasting change (e.g., immunization, adoption) or the improved experiences will need to be available throughout the child's period of growth.

(4) Because patterns of disadvantage or failure tend to persist once established, there is a need to intervene early in children's lives. On the other hand, sharply defined "critical periods" do not operate with respect to most areas of functioning and it is never too late to intervene.

(5) A programme of prevention must take into account the cost/benefit ratio. All preventive measures must be assessed in relation to: the importance of the area of functioning they are meant to influence; the likelihood of the measure making a real difference; the number of people who can be reached by the method of intervention; the disadvantages that come as side-effects (almost no effective intervention is free of these); political and ethical considerations (loss of personal freedom, imposition of remedies, etc.); and the cost of the preventive measure in terms of finance, resources and personnel.

(6) It is important to recognize that what is appropriate in one sociocultural situation may not be appropriate in another. Measures must be tailored to local circumstances and level of resources.

(7) Effective prevention often depends on appropriate legislative support.

2.1 Preventive measures immediately applicable

Mental health problems are known to be associated with both physical disease or disability and with a variety of psychosocial hazards and stresses. It is therefore convenient to summarize recommendations under the two headings of general health measures and social welfare measures.

2.1.1 *General health measures*

There is good evidence that children with any form of organic brain dysfunction (e.g., epilepsy, cerebral palsy, or encephalitis) or with mental retardation have a much increased rate of psychosocial and mental health problems. Accordingly, any measures that substantially reduce the rate of these conditions should also have mental health benefits. There is good evidence that children with chronic physical handicaps (of a kind that do not involve brain damage) also have a somewhat increased rate of mental health problems, although the increase is less than is the case with brain disorders. Thus, any improvements in the general physical health and wellbeing of children should also lead to gains in psychosocial functioning. The various steps required to prevent handicapping physical disorders and to foster optimal physical development have been considered by other WHO Expert Committees [1] and working groups and will not be reviewed here. However, some of the crucial elements are outlined below.

(1) Improved maternal and obstetric care. This is important because perinatal complications may lead to cerebral palsy and other forms of brain pathology, which in turn predispose to mental health problems.

(2) Improved nutrition. Prolonged malnutrition in early childhood remains an important main or contributing cause of death in developing countries. In those who survive, it not only impedes physical growth but can impair mental development, especially if coupled with a poor psychosocial environment. In this connexion the encouragement of breast-feeding and concern with the psychosocial aspects of physical care are important factors.

(3) Effective immunization programmes. In many parts of the world poliomyelitis, tuberculous meningitis, and tetanus (and to an important

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[1] WHO Technical Report Series, No. 600, 1976 (*New trends and approaches in the delivery of maternal and child care in health services*); WHO Technical Report Series, No. 609, 1977 (*Health needs of adolescents*).

extent measles, rubella, and pertussis) remain both killers and causes of chronic mental and physical handicaps. Immunization greatly reduces both mortality and morbidity.

(4) Reduction of accidents. Accidents are a principal cause of death in children. Survivors are often left with brain damage from head injuries. Steps to reduce accidents such as the imposition of speed limits on roads, road-sense training, and the provision of adequate play space for children are therefore important.

(5) Improved physical and social conditions. The control of most infectious disease depends at least as much on better living conditions and pure water supplies as it does on improved medical treatment.

(6) Better care of the chronically handicapped. Many of the adverse psychosocial sequelae to chronic physical handicaps are indirect consequences of the social restrictions, educational difficulties, inappropriate medical treatments, and stigmas associated with crippling conditions. Better support of families and improved medical, social, and educational care of chronically handicapped children would aid their psychosocial development and reduce mental health problems.

2.1.2 *Social welfare measures*

The extensive evidence showing associations between a wide variety of psychosocial stresses or disadvantages and mental health problems has already been mentioned. There is good reason to suppose that many of these associations reflect causal influences ; hence measures to reduce these stresses or to foster development would improve children's psychosocial functioning. The choice of measures recommended is based on three main principles : (1) the intervention should affect a substantial proportion of children ; (2) there is a reasonable expectation that the situation can be influenced by inexpensive procedures ; and (3) the intervention should utilize existing services. The recommended preventive measures are as follows.

(1) *The avoidance of unstable and discontinuous patterns of parenting*

Studies have indicated that children who repeatedly go in and out of children's homes or foster homes, or who frequently change from one home to another, or who live with their own parents in a severely unstable and unsettled family environment have a high rate of difficulties in their psychosocial development. There is also evidence that children from stressful, discordant homes are more likely to develop normally if they

are adopted than if they remain in a disturbed family environment. Accordingly, it is suggested that, in the case of young children whose parents seem unlikely to be able to look after them, an *early* decision should be taken with respect to adoption or long-term fostering. If not already in existence, appropriate legislation should be introduced to ensure that it is the children's needs that are paramount in such circumstances. For children who need long-term substitute care, a high priority should be placed on ensuring a stable family environment. Changes in foster parents or children's homes and recurrent admissions of children into short-term institutional care should be avoided.

(2) *Improved conditions in day-care facilities*

It has been shown that children's development is influenced by their experiences in day-care centres or nursery schools. It is important that there be continuity in the staff who take care of the children so that each child has only a limited number of people who look after him. However, there should be sufficient staff to provide them with play, talk and activities, and the centre should provide an adequate range of experiences and learning opportunities. An interaction between the day-care centre and the parents will help to increase parental skills and confidence.

(3) *Improved conditions in hospitals and other residential institutions, together with a reduction in admissions*

Children's behaviour and development varies systematically according to the social and psychological conditions in the institutions in which they live for either short or long periods of time. There is some evidence that a change in institutional conditions (as shown by hospital studies) leads to changes in children's mental health functioning. The principles of good care include all those already considered under day-care. However, continuity in the staff caring for a child is even more important in the case of residential facilities. This means that each child should be looked after by only a few staff who have a special responsibility for him rather than by a large number of changing staff who deal with a total group. Parents should be strongly encouraged to visit children daily in hospital and be able to do so without restrictions ; in the case of very young children it should also be possible for a parent to be admitted with the child.

It has been found that repeated hospital admissions are associated with an increased risk of psychosocial and mental health problems in later childhood. The risk is probably much greater among children already experiencing psychosocial stress or disadvantage. The implication is that every effort should be made to treat ill children as outpatients

or day-patients unless there are strong reasons for admitting them to hospital. Emphasis must therefore be placed on the development of community and outpatient facilities.

(4) *Reduction in the number of unwanted births*

Children whose conception is unwanted by their parents may subsequently become loved, but this is less likely to occur than in the case of children whose births were desired from the beginning. Children who are rejected are more likely than other children to have mental health problems. Clearly, it is no straightforward matter to take action to reduce the number of unwanted births. The free availability of family planning services is one important step but it is not enough. The individuals most likely to produce unwanted children (young single people and people with many personal and social problems) are just those least likely to avail themselves of services. Usually it is not that they wish to conceive a child or that they have ethical objections to contraception but rather that their difficulty in planning a family is merely one facet of a general problem in planning all aspects of their lives. Accordingly, family planning must form part of a wider community service that is educational in the broadest sense.

(5) *Enhanced public awareness of children's needs*

It is essential that high priority be given to the health and welfare of children and thus to the task of rearing children. Some of the psychosocial needs of children are implicit in the recommendations already made. Children learn through play, conversation, and experiences, on all of which emotional and intellectual growth depends. Parents need to appreciate the distress often experienced by very young children when away from home and to recognize that their clinging on return is a normal response. Sensitivity to differences in individual children's needs is important at all ages, as is the requirement for the right balance of emotional support and social control. It is also important for parents to realize that children are influenced by the emotional climate in the home. These are but a few of the general principles that people should know about children's needs so that they will be better able to respond appropriately as parents, as teachers, or indeed as anyone who comes into contact with young people. There are many informal opportunities for this learning to take place at home and at school, through antenatal discussions with the nurse or doctor, through health visitor contacts, and through hospital care. In addition, there are important opportunities in the use made of schooling and of the mass media. One example

of the former would be the inclusion of parenthood responsibilities in sex education curricula.

(6) *Monitoring*

While there is a strong expectation that benefits would accrue from these measures, which are in any case desirable in their own right, the best ways to intervene and the precise steps to be taken are not always obvious. It is necessary to determine the crucial elements needed to bring about the desired change and the cost/benefit ratios of the different approaches that might be followed. Operational studies are needed to examine the advantages and disadvantages of bringing about change and, in all cases, systematic monitoring and evaluation are essential.

2.2 Medium-term interventions

The preventive measures considered thus far, if introduced effectively, should bring important psychosocial benefits. Other mental health problems, however, would not be influenced by these measures because they are not causally connected with discontinuous parenting, institutional care, recurrent hospitalization, brain damage, or mental retardation. For the prevention of these disorders still other steps will be needed.

The measures recommended for immediate implementation were those for which there is sufficient evidence to justify action. With regard to those noted below, while immediate action is possible, further studies are required before large-scale programmes would be justified. Four areas have been selected as being of particularly high priority on the grounds that knowledge already exists to indicate their importance for psychosocial development, that they affect a large number of children, that some immediate preventive steps are possible, and that there is a strong likelihood that medium-term research would have the practical results needed to plan more effective primary prevention. These four priority areas are schools and day-care facilities ; patterns of child care in residential institutions ; urbanization and industrialization ; and protective influences.

2.2.1 *Schools and day-care facilities*

There is good evidence that children's behaviour and development are influenced by the social characteristics of the schools they attend, and schools thus have a responsibility for the child's psychosocial development as a whole as well as for the teaching of specific knowledge and skills. Steps can already be taken on the basis of what is known about children's needs to avoid some of the more obvious features of bad

schooling. However, information is still lacking on the most effective ways of fostering good schooling. Studies of this aspect of education should have a high priority in view of the implications for effective preventive action.

Other issues also arise. The importance of education in children's development is obvious in relation to scholastic skills. Certainly any measures to reduce the level of illiteracy may well aid psychosocial development. Accordingly, steps to improve educational standards and to provide help for children with reading difficulties are clearly indicated. However, the extension of educational coverage of the population will not necessarily reduce the level of psychosocial and mental health problems and in some circumstances could even increase it. The limited available evidence suggests that the main mental health disadvantages of reading difficulties or of low intellectual level do not stem directly from the low IQ or low reading attainment *per se* but rather from the experience of failure and social stigma. Hence, in a developing society the extended provision of education can increase the public identification of children with low attainment, and thus there may be a larger number of individuals who experience failure and its adverse psychosocial effects. If this possible disadvantage is to be avoided, it is necessary for any increased provision of schooling to be part of a system that does not stigmatize children of lesser abilities or attainments. Exchange of information about countries' successes in this respect is therefore highly desirable.

The importance of improved conditions in day-care facilities and the fact that knowledge already exists to bring these about has already been mentioned. However, there is still much to be learned. Most studies so far have been concerned with the effects of day-care on intelligence and on later school attainment. It is crucial that there be an equally sharp focus on the psychosocial consequences of different patterns of day-care.

2.2.2 *Patterns of child care in residential institutions*

During the course of their development many children are likely to experience some form of institutional environment in terms of residential nurseries, communes, or children's homes. Research has already shown that these experiences can have both good and bad consequences. Institutions are not in themselves either beneficial or harmful. Some support family cohesion and autonomy; others destroy and undermine family ties and responsibilities. Some provide a stimulating environment that encourages the growth of intellectual competence, ideas, individual responsibility, self-awareness and creativity; others are barren, and

lacking in all that is needed for psychological growth and personality development. Much is now known regarding the conditions needed for cognitive maturation but less is known about the features that facilitate optimal emotional and social development. Some immediate steps have been recommended to improve residential institutions. However, more effective interventions require further knowledge. There are important differences in the ways in which countries provide institutional services for their children, and investigations into the characteristics and effects of different patterns of residential child care would have direct and immediate implications for policy and planning.

2.2.3 *Urbanization and industrialization*

There is good evidence that delinquency and mental health problems both tend to occur much more frequently in urban areas and that this association reflects causal influences that are not entirely an artefact of population movement or case ascertainment. Therefore available knowledge about the adverse influences associated with city life should be used in town planning and community development to ensure children's psychosocial development. High priority should be given to the elimination of slum conditions and other unfavourable socioeconomic circumstances. In this connexion, it is important that members of the community be involved in the process of improving living conditions. For example, in some countries there has been large-scale construction of tower blocks in cities in order to provide more families with homes having kitchens, bathrooms, and other household facilities. However, while this has led to certain improvements, many families (especially those with young children) are dissatisfied with this form of housing. Similarly, industrialization has obvious benefits in terms of making it possible to raise living standards. On the other hand, the move from rural areas to cities has sometimes disrupted family ties and destroyed community cohesion. It is therefore recommended that mental health professionals should participate with those responsible for planning to help ensure that psychosocial needs are fully taken into account.

However, little is known about the ways in which some cities predispose to mental disorder and family discord. It is important to note that this ill-effect does not apply to all cities. It appears that cities need not have high rates of disorder, and it is essential that we identify how cities might be modified in order to bring about mental health benefits. This is particularly important in the developing world where the process of urbanization and industrialization is creating new urban environments and extending city boundaries all the time. Special problems requiring

investigation are involved in refugee camps and in the shanty towns that are growing up on the boundaries of some cities.

The effects of greater affluence are similarly controversial. Obviously it is right to strive to improve general living standards and it is equally obvious that any rise will have real and important benefits for families.

However, all too often the socioeconomic gains are not accompanied by measures to improve the quality of family life. Indeed, sometimes the actions leading to greater affluence have had the consequence of weakening aspects of parenting, of family life, or of those community relationships that facilitate psychosocial development. Improvements in overall living standards will not automatically have any mental health benefits. The challenge for the future lies in ensuring that socioeconomic advancement enhances rather than impedes psychosocial functioning and mental health. Exchange of relevant experience between all countries implementing and evaluating practical policies to raise living standards for their citizens is urgently needed, as are studies to determine the effects of such measures on psychosocial development and mental health.

2.2.4 *Protective influences*

Another potential opportunity for effective psychosocial intervention is provided by the observation that most children do not succumb to stresses or disadvantages. While there has been extensive research into the factors that result in psychosocial development becoming disordered or deviant in some way, very little attention has been paid to the factors, circumstances, or conditions that enable normal development to continue in spite of stresses or disadvantage (see also Part I, section 2.4.5). A shift of research focus is needed from vulnerability to invulnerability, from damaging to beneficial influences, from failure to success. Of course, in this connexion it should not be assumed that the ameliorating factors for one set of stresses will be the same as those for another set. Nor will the influences that help a child in an inner city slum necessarily be the same as those that benefit a child living in a nomadic rural community. It is for these reasons that international collaboration and comparisons between different societies are necessary. WHO has a crucial role to play in fostering and coordinating such work.

2.3 Other possibilities of prevention

2.3.1 *Parental mental disorder*

There is abundant evidence that the children of mentally ill adults—especially those with personality disorders or chronic neuroses—have a

substantially increased risk of psychiatric disorder. A reduction in the rate of parental mental disorder or of chronicity and the disabilities associated with it would undoubtedly have benefits for children, but while effective treatment for many adult mental disorders is available little is known at present on methods of reducing incidence. Steps to reduce the environmental impact of parental mental disorder would be useful, but again there is a lack of measures that are likely to prove effective.

2.3.2 *Family discord*

While no effective means are yet available for reducing the discord in disturbed and disharmonious families, consideration should continue to be given to this question because of the great reduction in child psychiatric disorders that an improvement would bring. In all the cultural settings in which the matter has been studied it has been found that disrupted personal relationships within the family are strongly associated with mental health problems and deliquency, and there is reason to believe that the association reflects a causal relationship. Thus any reduction in family discord would be likely to improve child mental health.

2.3.3 *Parenting deficiencies*

It is highly desirable that means are found to improve the quality of parenting but there are a few useful leads on how this might be done. Educational approaches during childhood and adult life are worthwile, but it is likely that experiences are more important than instruction. Improvements in family life are likely to help children to acquire the skills they will later need as parents. Also it may be of value to provide adolescents with supervised experience in looking after younger children so that they may better appreciate children's needs. These are worthwhile areas to explore, but at present they are still too tenuous to form the basis of anything other than an experimental preventive programme.

3. TREATMENT MEASURES

In recommending treatment measures the Committee endeavoured to select those that can be utilized by professionals from a variety of backgrounds (e.g., nurses, social workers, and teachers). Indeed, many of them can be undertaken by primary health workers. In addition, the Committee chose methods that are effective, simple to apply, readily

taught, not unduly time-consuming, and without severe or frequent side-effects. Attention was also paid to the need for measures to be carried out with limited resources.

The emphasis in the measures described below is primarily on short-term methods, but the Committee recognized that some children suffer from chronic problems and need continuing care. The term " treatment " is used to imply the use of a technique to improve a child's understanding or behaviour. The failure of such treatment makes it even more important to have available people who will continue to take a concerned interest and so help to limit the handicap as far as possible. For some children—those who have been neglected in institutions, for example—there is a need for long-term rehabilitation in the community. This can be time-consuming and costly, but in the long run it is likely to be more effective and less expensive than keeping the child in the institution.

3.1 Measures found to be effective in evaluative studies

3.1.1 *Behavioural methods*

Behavioural methods aim to modify behaviour through the use of techniques based on knowledge about learning processes and about the factors that influence learning. These techniques include the systematic application of well timed encouragements or rewards ; deliberate non-response to inappropriate attention-seeking behaviour ; the changing of behaviour by small, carefully graded steps ; the teaching of coping skills ; and the provision of effective feedback to the child on his behaviour and biological responses. Such measures can be applied by both professionals and parents. Their efficacy has been shown with respect to a variety of problems including bedwetting, isolated fears, obsessions, aggression, and disruptive behaviour in the classroom. It is, of course, important that behavioural methods should not be undertaken mechanically but used with a sensitive awareness of the child's emotional needs.

3.1.2 *Focused short-term counselling*

Short-term counselling involves exploration and discussion of both inner feelings and real-life situations. It emphasizes behaviour change through insight, understanding, advice, suggestion, and the use of a therapeutic relationship. Such short-term intervention (lasting only a few sessions) can be carried out by nonpsychiatric professionals, is not unduly expensive, and is effective in the treatment of children's emotional problems and of family difficulties affecting normal psychosocial devel-

opment. Not all nonpsychiatric professionals are suitable to undertake such counselling, and training is more time-consuming and costly than is the case with behavioural methods. However, the principles involved can be applied to a wide range of problems as well as to the promotion of child mental health.

3.1.3 *Drugs*

Drugs play a small but important role as therapeutic agents. Stimulant drugs have been shown to have short-term benefits in the treatment of some forms of severe over-activity; tranquillizing agents are sometimes effective adjuvants in the treatment of severe anxiety; and antidepressants have a place in the treatment of persisting depression in children and adolescents.

3.2 Probably effective but more costly measures

3.2.1 *Hospital treatment*

Although required for only a small minority of mentally ill children, inpatient care is clearly needed and may be effective in some cases. The need mainly arises when:

— behaviour is too disturbed to be managed elsewhere (e. g., some psychotic disorders)

— emotional disorder is associated with severe medical conditions (as in some cases of intractable asthma or epilepsy)

— there is a life-threatening condition (as in some cases of anorexia nervosa or suicidal depression)

— intensive intervention is required in conditions not manageable at home (as in some cases of child-battering or severely disordered parent–child interaction)

— situations arise requiring a controlled separation of the child from his family (as in some severe cases of refusal to attend school)

— the main therapeutic action requires manipulation of the child's total environment.

Only infrequently is admission required specifically for examination or observation. Isolation of the child from his home environment has often proved a serious disadvantage; inpatient care, for example, is now only occasionally advisable in the behavioural treatment of autistic children.

3.2.2 *Special educational or residential services*

There has been little evaluation of special educational or residential services for children with mental health problems or disorders of psychosocial development. Nevertheless, such services are sometimes required and are effective in selected cases—for example, when there is a need for particular teaching skills (as with autistic children or with those showing severe specific reading retardation), when the child's mental health needs require a particular type of caring environment in the school (as with some severe emotional disorders), and when behaviour is too disruptive to be contained in ordinary classrooms. Residential provision may be needed because therapeutic education or care is needed on a round-the-clock basis, because some children must be cared for away from a grossly disturbed family situation, or because it is impracticable to provide day-care locally owing to the variety of the disorders and the specialized nature of the children's needs. While it is generally accepted that many children have special educational needs, it remains uncertain how far they may be met by specialist advice in ordinary schools, by special classes, by special day schools, by residential schools, or by hostels in which the children attend ordinary schools. Wherever possible it is desirable and less expensive to provide help within ordinary schools, but there will always be a need for special day schools or units for the severely mentally retarded and for a certain number of residential schools.

Further, there is evidence to suggest that there are definite advantages for specific groups of children (severely socially disruptive and autistic) in the provision of a rather specialized type of education that puts emphasis both on the caring environment and on regular and systematic reward for appropriate behaviour.

3.2.3 *Specialized psychotherapy*

Specialized methods of psychotherapy include the following.

(1) Group therapy. This method has been used for a number of years, particularly with children who show difficulties in social relationships. It has also been found useful to conduct group therapy among parents whose children have similar mental health problems. Although evaluative studies have not produced clear-cut results, it seems likely that this form of treatment is effective in selected cases.

(2) Focused family therapy. In this form of therapy parents and children are seen conjointly for improvement in communication over

important issues within the family. This has not been adequately evaluated, but it seems likely that it may be effective when individual problems stem from faulty intrafamilial communication.

3.3 Measures found ineffective when tested in some countries

Personal counselling of children whose behaviour presages later delinquency has been systematically assessed a number of times and has been shown to be ineffective in the prevention of further delinquent acts.

Unfocused psychotherapy of indeterminate length has been evaluated in a small number of studies. Although it is difficult to be sure that this approach is without value in all situations, existing knowledge suggests that it is only occasionally effective.

3.4 Measures that have not been evaluated and cannot be recommended

Psychotherapy, which has as its aim the promotion of insight through the medium of symbolic thought, is unlikely to be effective where the capacity for symbolic thought is greatly diminished, as in childhood autism.

Insight-oriented individual psychotherapy, drugs, or any other form of treatment directed solely towards the child should rarely be the only or main mode of intervention when disorders are due to continuing stresses or abnormalities in the child's psychosocial environment. Treatments need to be devised to improve the child's environment and not just to help him adapt to disadvantage.

The routine long-term use of drugs for children with learning difficulties and disciplinary problems at school is not recommended both because the long-term efficacy of drugs has not been proved and because adverse effects on growth and mood can occur.

4. RESEARCH IMPLICATIONS AND PRIORITIES

During the past 10–15 years important advances in child mental health and psychosocial development have been made. Concepts have been clarified and there has been a fruitful cross-fertilization between research on normal development and that on disorders of development, in particular with regard to the various interactions between the developing child and his psychosocial environment. Not only have new knowledge and better treatment and prevention measures become available but new areas of investigation have been identified. The Committee

recommended three priorities: the evaluation of interventions, the development of measures for prevention and treatment, and the application of comparative epidemiology.

4.1 Evaluation of preventive and therapeutic interventions

Methods in current use for the prevention and therapy of mental illness are seldom monitored or evaluated, and there is consequently a danger of continuing to use ineffective measures. There is also the opposite danger, when new techniques are introduced, of abandoning measures that are in fact effective. The evaluation of existing measures is therefore essential. The Committee recognized that the evaluation of preventive and therapeutic interventions is difficult for several reasons. Firstly, interventions are usually complex and multifaceted. Thus the finding that " psychotherapy ", " counselling ", or " nursery schooling " are or are not effective is of little value as a guide to action without detailed knowledge about the specific intervention. Secondly, there are difficulties in obtaining the most appropriate output measures. Thus most studies of preschool interventions have been evaluated in terms of their effect on intelligence simply because intelligence tests are readily available, yet the interventions were generally planned to effect changes in quite different aspects of psychosocial functioning. Thirdly, many of the benefits are likely to be long-term rather than immediate. For instance, it would not be expected that improved housing would have a significant short-term impact on mental health. All these difficulties can be overcome by appropriate planning and investigative work. WHO has a central role in this connexion.

4.2 Development of measures

Many of the advances to which reference has been made were possible only because of the development and availability of appropriate methods of diagnosis and classification. Over the past 10 years WHO has made a major contribution in the classification of child psychiatric disorders and in the exploration of multi-axial systems of classification (see also Part I, section 2.1). However, much remains to be done and it is essential to continue to build on past achievements.

It is important to assess the validity and usefulness of the new rubrics in the ninth revision of the International Classification of Diseases.[1]

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[1] *Manual of the international statistical classification of diseases, injuries, and causes of death, 9th revision.* Geneva, World Health Organization, 1977.

Apart from evaluation of the classification as such, there are various diagnostic questions that require international collaborative research. For example, the hyperkinetic syndrome is diagnosed much more frequently in some parts of the world than in others and it is pertinent to ask whether this major variation reflects differences in diagnostic practice or real differences in the incidence of the disorder.

While the value of multi-axial approaches to classification has been recognized, it is necessary to explore further the merits, demerits, and limitations of these approaches.

The research already undertaken by WHO in this field has highlighted the need for methods of measuring the psychosocial environment that could be applied in a variety of countries and cultures. Psychosocial variables are of crucial importance in children's growth and maturation, and it is essential that we develop better ways of assessing and classifying characteristics of family interaction, institutional life, societal influences, and patterns of cultural change. In this connexion the Committee stressed that there should be an emphasis on the positive influences as well as on the negative factors.

Most of the research undertaken on diagnosis and classification has been concerned with clinic or hospital practice. It is therefore urgent that assessment and diagnostic tools now be developed that could be utilized in primary health care.

4.3 Comparative epidemiology

We are living at a time of rapid social change. In many developing countries considerable modifications are taking place in patterns of life as a result of such factors as urbanization, industrialization, population movement, introduction of universal education, changes in the role of women and men, and breakdown in tribal structures. It is very important to study the mental health and psychosocial sequelae of such changes in order to determine the pattern of effects and influences. Many of the alterations in social conditions are an inevitable consequence of economic development. Moreover the changes involve both advantages and disadvantages to the people concerned. Research is needed to identify and delineate those aspects of social change that are beneficial and those that are not. How can industrialization occur so that the benefits accrue but the deficits do not follow ? What is needed to ensure that the changing role of women in society fosters the best in family life and child-rearing ? It is also important to obtain information on the variations between societies and cultures in patterns of normal psychosocial development.

49

Comparative studies using the epidemiological method could provide answers to these and other questions essential to the planning of improved preventive and therapeutic services. Three main types of comparisons are required. Firstly, there are comparisons between different areas, societies, or living conditions. Thus, it would be useful to compare the characteristics of cities with high and low rates of mental health problems, or to compare rates of disorder in cities differing greatly in features thought to be of possible importance (e.g., rate of population change, sociocultural heterogeneity). Similarly, it would be useful to determine how schools with a high frequency of psychosocial problems differ from those with a low frequency of these problems. Secondly, there are comparisons over time. We have already noted the importance of studying the mental health consequences of industrialization, migration to cities, and introduction of universal schooling. Thirdly, there are comparisons within groups. Here the most important need is to determine individual features and experiences that differentiate the children who have a normal psychosocial development in spite of stress and disadvantage from the children who develop mental health problems.

The mechanisms already exist for WHO to foster research of the kind suggested. However, if the maximum is to be achieved and in particular if the research is to lead to effective preventive and therapeutic interventions, it is necessary to establish innovative coordinating mechanisms that would facilitate the exchange of information. In this way it may become easier to improve research methods, to ensure comparability between parallel investigations, to note new health and social issues that require investigation, and to consider the practical or policy implications of research findings as they become available.

5. SERVICE PROVISION AND PERSONNEL DEVELOPMENT

The majority of effective interventions in child mental health care are based on human interactions, which can take place in simple surroundings such as homes, schools, health centres, or dispensaries. Using these places as foci for services will make child mental health care more readily available to the whole population. This approach fits well with the overall policy of many countries, which emphasizes the development of primary health care, community health centres, and infant welfare clinics.

The mental health of children is inextricably linked with their psychosocial development, so that all those concerned with the growth and

development of children and with the process of socialization and education can contribute to the promotion of child mental health. Services should therefore be provided jointly by health workers, teachers, social workers and others. These workers need to have close communication in their daily work and divide among themselves responsibilities for different tasks.

The Committee was unanimous in its opinion that education and training of existing personnel as well as an overall increase in numbers should receive top priority in any programme to improve child mental health. Since most children cope with a variety of life stresses most of the time through the support of their immediate family, services should aim primarily to enhance normal family functioning by helping parents to help their children, rather than provide only direct child-centred interventions. Families should be encouraged to seek help early, before patterns of maladaptive behaviour become established, and to retain responsibility so that their capacity to cope with problems in the future can be strengthened.

5.1 A national programme of training and education

In many countries great stress has been placed on maternal and child health care, and public health nurses are trained to carry out regular checks on the physical health status of young children, to provide advice to mothers (especially on nutrition), and to immunize children. These tasks are being increasingly reassigned to more simply trained workers in order to reduce cost and expand coverage. Relevant mental health care should be included in the training of such health workers as well as others who have regular contact with children—namely, general physicians, paediatricians, medical assistants and those working in school health services, teachers, social workers, the police, probation officers, religious leaders, and the staff of child day-care centres, residential homes, and correctional institutions for adolescents. It is known that in many countries the help of traditional healers of different kinds is sought by many people although there is no clear information about the numbers of children treated by them. Some of their methods may be harmful (such as the treatment of epilepsy with substances that are harmful or have toxic side-effects), but others are not and may be beneficial. Inasmuch as traditional methods reflect the established values of the community and contribute to social cohesion, they are likely to be helpful and supportive to normal child development. In those instances where traditional health workers are being trained to work in collaboration

with modern health services (e.g., traditional birth attendants), their training should include the psychosocial aspects of care.

The Committee therefore recommended that the planning of a national training programme should start with a careful review of the work of existing personnel concerned with children. The aim of this initial review would be to obtain estimates of:

(1) the numbers and distribution of each category of worker and their availability to the community;

(2) the nature of their education and training (e.g., duration, curricular content, training methods, practical experience);

(3) the nature of their work with children (e.g., frequency of contact, tasks performed, the age of children seen).

This review would provide a basis for setting new educational objectives for each category of worker, which should reflect the priority needs in the field of child mental health as defined within each country. The criteria for selection of priorities are generally accepted and include: the frequency of a given problem; its seriousness in terms of personal suffering, disability, and socioeconomic consequences; the degree of community concern; and the availability of simple, inexpensive, and effective management techniques. In the case of child mental health problems, priority selection entails two special considerations. Firstly, many disorders represent quantitative rather than qualitative deviations from normal function, and arbitrary definitions may be necessary to establish their frequency. Secondly, in assessing the seriousness of a disorder, social consequences such as educational failure or family dysfunction need to be considered as well as personal disability.

The educational objectives would be:

(1) to give all workers a basic knowledge of the normal psychosocial development of children and the factors known to influence it;

(2) to give all workers a full understanding of the links between physical and psychosocial wellbeing;

(3) to provide skills and sensitivity in detecting child mental health problems at as early a stage as possible;

(4) to equip workers to carry out defined tasks of established effectiveness.

The careful selection of priorities and setting of educational objectives are essential if realistic tasks in mental health care are to be defined.

It is better to err on the cautious side initially and to set very limited objectives rather than risk overburdening workers, which may lead to failure and resistance to further attempts.

It is important that training be given in :

— the recognition of children with physical disorders that may cause psychiatric and/or developmental problems (e.g., children with cerebral palsy, epilepsy, asthma, locomotor disorders, deafness, or blindness)

— the early recognition, assessment, and treatment of children with learning disability or behavioural problems in school

— the detection of mentally retarded children in infant welfare clinics and the provision of family counselling and specific advice.

Educational objectives may include health education on, for example, the principles of general child care, family spacing, the prevention of accidents, adequate nutrition, child development (including avoidance of unnecessary anxiety over milestones), enuresis, and common transient symptoms. Health education is also useful in establishing a positive early mother–child relationship through encouraging appropriate attitudes on the part of parents and helping them to understand their child's individual characteristics.

Training to achieve these educational objectives should become an integral part of the curricula of nursing schools, teacher training colleges, medical schools, schools of public health, etc. In-service brief and practical training programmes can allow those workers already active in the field to assume new roles in child mental health. Such in-service training would be specially important for auxiliary workers in day-care centres and residential homes. Manuals are a useful educational tool, the modification of existing manuals probably being more effective than the production of separate manuals on child mental health. Post-graduate training would also be important, particularly for paediatricians, general physicians, and psychiatrists.

Adequate support and supervision must be given to personnel in direct contact with the population. For this reason staff who assume positions of responsibility need knowledge and understanding of the psychosocial development of children and of the kinds of problems that arise in providing services. Administrators of health, social welfare, and educational programmes need to be convinced of the value and feasibility of simple interventions. A valuable initiative is to arrange workshops and seminars in which head teachers, public health adminis-

trators, senior nurses, social work supervisors, and senior police officers interact with child mental health professionals. By this means it is possible to increase the awareness of the many people who have contact with children and at the same time to enable the mental health professionals to appreciate further possibilities for action.

Training is also needed with regard to the use of potentially harmful or dangerous types of treatment. For example, psychoactive drugs for children are sometimes used indiscriminately when physicians lack skills to intervene through counselling or behavioural techniques. In selected cases, the time-limited use of drugs is helpful, and maintenance therapy may be needed for children with epilepsy. A limited range of drugs should be used according to clearly defined criteria. The report of a WHO consultation on drug treatment for neuropsychiatric disorders in developing countries, held in March 1976, provides clear guidelines for such rational drug use.[1]

5.2 Service structure

Mental health services for children, as envisaged by the Committee, should be decentralized, integrated, and coordinated. Decentralization means that responsibility for implementation is borne by the periphery and located in the district management office. Integration implies that child mental health services are not a separate entity but an integral part of existing health, education, and social services. Coordination means that the efforts of the various services are decided upon, implemented, and evaluated jointly by the different sectors of community services. While such a structure provides great advantages in ensuring synergistic rather than parallel action and in making best use of existing resources, there are also potential difficulties in coordinating the actions of different services. Administrative skills are therefore of great importance in staff responsible for district management. This need should be reflected in training programmes. Regular supervision of peripheral workers is essential. One method would be to hold regular meetings of staff drawn from different sectors working in the same geographical area to discuss the child mental health problems encountered.

In the basic health services, all necessary preventive measures should be undertaken (e.g., the immunization of children against measles and tuberculosis ; the immunization of adolescent girls and women of child-

[1] Unpublished WHO document No. OMH/76.2. Copies of this document are available from the Division of Mental Health, World Health Organization, 1211 Geneva 27, Switzerland.

bearing age against rubella). It should be stressed that in developing countries prevalent communicable diseases place many children at risk of psychological impairment and that there is a need not only for prevention but for early treatment and follow-up. Special attention should also be given to the psychosocial causes and consequences of malnutrition in children. Malnourished children become miserable and apathetic and this may lead their mothers to ignore or even reject them. Psychological support for mothers leading to increased psychosocial stimulation of children should be an important part of nutritional rehabilitation.

Only after detailed consideration of the objectives and requirements for child mental health in basic health services and in schools should plans be made for the more centralized services, using wherever possible existing facilities in paediatric and psychiatric clinics and in inpatient units. Where residential care is essential, small units should be established.

In some developed countries an extensive network of specialist child psychiatric services or other psychosocial services exists (e.g., child guidance clinics, units in children's hospitals, remedial education, rehabilitation services, developmental screening clinics). Since the cost/effectiveness of such specialist services has not been established, the Committee strongly cautions countries with limited resources against uncritical adoption of an extensive network of specialist services. The potential dangers are that scarce trained manpower inevitably find their time fully occupied in clinical work serving relatively few patients, coverage remains extremely limited, and staff do not have time to train and supervise workers in the peripheral health services.

5.3 Evaluation and monitoring

One of the consequences of a decentralized, intersectoral approach to service provision is that sources of information about the service will be widely scattered. Since simple reliable information is an essential requirement for evaluation and monitoring, existing reporting systems in the basic health services and schools should be modified to provide such information, which should where possible include: (1) numbers of children with identified mental health problems, (2) the interventions used, such as drugs and counselling sessions, (3) information about supervision, such as meetings and visits to peripheral units, (4) referrals and admissions to hospital and (5) indicators of psychosocial problems, such as number of school drop-outs, rates of truancy and delinquency, and calls on child welfare services. Such information should be made quickly available in order to allow rapid detection of problems or failures

in the service, including, for example, the identification of communities with a high frequency of child mental health problems. Routine information collection of this kind also provides the basis for defining specific objectives and targets as part of the planning process (e.g., the reduction of drop-outs from primary school by a given percentage over a defined period of years).

In addition, evaluation can be based on more detailed observations in limited areas. This can take the form of operational research ; new strategies are introduced into an area and their effectiveness is compared either with a " control " area or with the situation existing during the pre-intervention phase. Training programmes should also be systematically evaluated.

6. PLANNING AND COORDINATION

Childhood mental disorders and problems of psychosocial development constitute a serious public health problem to which existing services provide an inadequate response. Means of primary prevention and types of therapeutic services have been described that could decrease the extent of childhood mental disorders, limit their harmful consequences, and improve psychosocial development. By implication, services for children with mental disorders should be extended. The Committee was aware, however, that a simple recommendation to extend services is unlikely to be helpful to health planners who, particularly in the developing countries, are already aware of many other health problems for which an increased level of intervention would be fully justified. Steps have therefore been indicated whereby planning for child mental health services can become part of the general planning process for health and for other sectors such as education and justice, leading to a rational allocation and utilization of resources. Such planning is most likely to be effective where there is a recognition of the importance of links between health, education, and welfare services and of the need for intersectoral collaboration.

6.1 Constraints in planning

In many countries of the world, mental health services for children have not been included in the national health planning process. There are several reasons for this.

(1) *Situation analysis*

The planning process is often dependent on information from existing services, but in many developing countries virtually no special services yet exist for child mental disorders. Therefore, since few admissions or outpatient attendances for child mental disorders are reported national health information systems cannot reflect needs. It is not realized that many children being brought to health centres or paediatric clinics may have emotional or behavioural problems that are not properly diagnosed and that many more simply do not reach any services but become permanent educational and social failures.

(2) *Identification of problems and formulation of objectives*

A lack of relevant skills and knowledge is evident among health planners and public health administrators. Adequate mental health training has only recently been introduced into medical schools and is still seriously deficient in many parts of the world. In many public health training courses the mental health component is inadequate both in extent and content. The situation is even worse with respect to training in child psychiatry and child mental health. It follows that many senior health planners are unable to make decisions concerning priorities, interventions, and planning of services in this field.

(3) *Formulation and selection of strategies*

The problems of health planners are matched by a lack of public health orientation among many child psychiatrists. Training in child psychiatry is long, complex, and costly. It often involves initial experience in both adult psychiatry and paediatrics, followed by several years of clinical work in child psychiatry. In many countries great stress is placed on individual psychotherapy to the relative exclusion of other therapeutic approaches. Many emerging specialists have limited epidemiological knowledge and few skills in evaluation or selection of priorities from a public health point of view. In those countries with a relatively large number of child psychiatrists, the efforts of these professionals are not being directed to problems of major public health concern.

(4) *Programme formulation*

Child mental health workers share large areas of common interest with workers outside the health sector—notably with those in education, juvenile justice, and social welfare. Effective planning is not possible

without their coordination. In the absence of mechanisms for coordination, workers in each sector tend to assume that " the others " are dealing with the problem, and in the end nothing is done. Linked to the problem is the ambiguous status of services provided by voluntary organizations. Deficiencies in public services have driven voluntary associations (particularly in the field of mental retardation) to start diagnostic clinics, schools, counselling services, and psychosocial services financed by contributions from the general public but often (as with some government services) having to charge fees. The result is that in many developing countries one or two such institutions exist in large towns, providing services for a highly selected segment of the population. The voluntary associations are themselves painfully aware of their failure to reach children needing help in rural areas or poor children in urban areas. Such voluntary services have a valuable function in demonstrating the potential for care accessible to the whole population. This should serve to encourage government officials to plan for better child mental health services, but paradoxically it is sometimes used as an excuse for inaction.

(5) *Evaluation*

Evaluation raises the question of the time-scale over which the social value of interventions must be assessed. In the health sector, planners expect effective services to lead to a reduction in mortality or morbidity after not more than 2–3 years. The process of psychosocial development in children, however, takes place over two decades. Governments are fully aware of the pressing need for better and more widely available education, with the prospect of social benefits after 10–15 years. The same perspective, however, is rarely applied to the assessment of benefits likely to result from improved child mental health services. Related to the issue of time-scale is the problem of identifying short-term, intermediate, and long-term indicators of effectiveness. Although the benefit to communities might be seen in increased social satisfaction and enhanced economic development it is unlikely for these to be demonstrable. Therefore attention should be paid to more closely related phenomena —e.g., rates of drop-out from school, incidence of family discord, and rates of delinquency and of emotional disorders.

Finally there is the problem of the " shifting baseline ". Social transitions (such as rapid urbanization, changes in family structure, and increasing numbers of surviving children with brain damage) may increase the risk of impaired psychosocial development and child mental disorders during the period in which interventions are being introduced.

This gives rise to the problem of formulating objectives in quantifiable terms, but it is no argument for failing to act. Rather, it strengthens the argument for taking a critical attitude to the criteria used for evaluating impact.

In summary, it can be seen that if child mental health services are to be included in the national health planning process a number of problems have to be faced. At the level of national policy formulation, ministerial responsibility for the psychosocial development of children may be undefined, particularly in its mental health aspects. Within the planning process itself, difficulties occur at several stages : (1) situation analysis, (2) problem identification and formulation of objectives, (3) formulation and selection of strategies, (4) programme formulation, and (5) evaluation.

The problems outlined above can be readily overcome at national level once their nature has been fully analysed and understood. When this has been done the planning of child mental health services will have one outstanding advantage over planning in other sectors : *many of the important interventions to be introduced will not involve structural changes in the health service or the setting up of specialized institutions, treatment facilities, or supplies*. A useful beginning can be made by reorienting the concerns and skills of current staff, but this should be followed or accompanied by an increase in available resources. The potential for development in this way is enormous.

6.2 Steps to facilitate planning

6.2.1 *A national policy*

The first vital step is an expression of national commitment through a policy directive from the appropriate political and governmental bodies, both at the central and local administrative level. This requires a careful and realistic action plan. The policy must make it clear that the responsibility for problems concerning child mental health and psychosocial development are intersectoral. The policy statement should give guidance for the overall line of action in relation to general socioeconomic policy and should take into account priorities and policy decisions in related fields such as housing, the relocation of communities, women in employment, and the extension of compulsory education. The policy should also give explicit guidance concerning the coverage to be provided by the service and the priority groups that must be provided for (e.g., rural populations, migrant groups, those living in deprived periurban areas,

and adolescents). It would also be appropriate to establish at the national level the rights of children, particularly those at considerable social disadvantage (e.g., the mentally retarded), with reference to the relevant declarations of the United Nations General Assembly.[1]

6.2.2 *Mechanisms for coordination*

In order to improve coordination between departments at a national level so that all needs of children, including psychosocial needs, are met, it is suggested that a coordinating committee should be designated in every country. In countries with a federal system of government, this committee should function at the state or provincial level. The precise terms of reference—whether, for example, it should have any executive powers—would be a matter for individual governments to decide. But its basic function should be to review regularly the needs of children. It would ensure that the needs of particular groups are being met (e.g., the emotionally disturbed, the mentally retarded, and those with learning disabilities), consider the need for new legislation or examine the psychosocial implications of existing legislation (e.g., regarding adoption procedures and powers of compulsory admission to hospital), examine training gaps (e.g., for health, social, and educational workers in residential institutions for children), and assist in formulating national policies affecting children (e.g., regarding children's rights, housing, education, and part-time employment for mothers). It is desirable that such a committee should not be too large if it is to function effectively. Criteria for selecting members should be explicitly based on the needs of children rather than on different professional groups.

The committee would probably be most efficient if specific issues were dealt with by setting up small working parties including people outside the committee with specially relevant skills or experience. Such working parties would function only until the necessary recommendations were

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[1] The relevant declarations are as follows:

(1) Declaration of the rights of the child. In: *Human rights: a compilation of international instruments of the United Nations*. New York, United Nations, 1967, pp. 89–90.

(2) Declaration on the rights of mentally retarded persons. In: *Resolutions adopted by the General Assembly during its twenty-sixth session*. New York, United Nations, 1972 (Official records: twenty-sixth session, supplement No. 29, A/8429), pp. 93–94, resolution 2856 (XXVI).

(3) Declaration on the rights of disabled persons. In: *Resolutions adopted by the General Assembly during its thirtieth session*. New York, United Nations, 1976 (Official records: thirtieth session, supplement No. 34, A/10034), pp. 88–89, resolution 3447 (XXX).

prepared for consideration by the committee and transmission to the relevant government department for action.

When considering a programme for a specific group of children (e.g., the blind, the emotionally disturbed) the recommendations of the working party may have to specify : (1) which group of workers should be assigned the central responsibility for the execution of programme activities ; (2) the type of information that should be collected (and methods for its collection) in order to allow the evaluation of the programme ; (3) the degree of coordination needed and the mechanisms required to achieve it at various levels of service organization and between various sectors ; (4) the resources necessary for programme implementation and possible ways of obtaining them ; (5) gaps in knowledge and possibilities for research.

The approach taken by a working party towards a problem would be dictated largely by the availability of knowledge and resources and the importance of the problem for the nation. In some cases, enough knowledge would be available to determine action, and the task of the working party would be to recommend means of implementation. In other instances, the available information might dictate a more cautious approach and the introduction and evaluation of alternative interventions on a limited scale.

Mechanisms of coordination will also be needed at provincial, district, and local levels. There should be clear rules concerning the referral of children from one sector to another, and wherever possible interventions themselves should be coordinated. In nearly all cases, the reference point for service provision will be the family, and it is important that family members be fully informed of intervention plans and understand the respective role of each agency. The community should also be involved in the planning of any child mental health programme and in any subsequent modifications of that programme.

6.2.3 *Centres for training and research*

There is a need in all countries to have a centre or centres that can provide training and carry out research on child mental health. In some countries such centres already exist, and in others it may be possible to pool resources and create one. The centre should be staffed by a multidisciplinary team. Its composition should vary according to needs and resources but it might include a child psychiatrist, a psychologist, a nurse with specialist training, an educator, and a social worker. Leadership is important, but the preponderance of any one professional

group should be avoided. In establishing such a centre, the following guidelines should be considered.

(1) There should be close and continuous contact with those responsible for training in paediatrics, public health, psychiatry, nursing, teaching, and law enforcement.

(2) The time and resources available should be devoted to a wide range of training activities; undue concentration on one profession should be avoided.

(3) The centre should develop training materials and curricula, according to local needs and sociocultural conditions and established educational objectives, and should undertake training activities outside the institution itself. Sections for manuals used by auxiliary health and education workers should be prepared.

(4) The centre should have access to peripheral health services and should serve as both a back-up facility and an in-service training source.

(5) The centre should have an active service commitment (outpatient clinics, diagnostic services, consultation services) and a link with educational services and juvenile courts. This should include a total service commitment to a particular geographical area. Ideally, in order that training should be relevant to local conditions, this would include some responsibility for a rural area as well as direct service to the local population.

(6) Relevant research should be carried out by the centre, which should therefore work in close collaboration with the committee described in section 6.2.2 above.

PART III

RECOMMENDATIONS

1. INTRODUCTION

This report is aimed at assisting those who have the responsibility for formulating national policies, for deploying financial resources and personnel, and for developing preventive and intervention services relating to the promotion of mental health and normal psychosocial functioning of children.

Access to mental health services and protection from mental disorders are rights of all children, which the community has a duty to provide. Mental health should not be viewed separately from physical health or social wellbeing and is equally important in the socioeconomic development of a nation. Although children today form more than a third of the population of the world and almost half the population of developing countries, services for the mental health needs of children in many areas are inadequate or completely lacking. The stresses caused by rapid social changes such as industrialization and population growth may threaten the normal development and mental health of children. These stresses need to be identified, and children who appear to be vulnerable to them must be given special attention. Services for children cannot be postponed. Without them it will be impossible to meet the basic needs of children, many of whom may consequently suffer from permanent defects of personality. Development plans should make equitable provision for the social needs and welfare of children and families, providing opportunities for the healthy growth of all members of society. The expenditure incurred in the provision of such services need not be excessive.

Governments are urged to recognize that the mental health of children has high priority for compelling humanitarian reasons and because mental disorders among children may presage unproductive adult lives. Moreover, mentally ill children may themselves perform poorly as parents so that their own children will in turn be born into a condition of severe deprivation and run a high risk of mental disorder.

In countries in which infant mortality rates are high, epidemics are frequent, and starvation is a constant fear, it may be felt that concern for childhood mental health is a luxury. In fact, there is no conflict. Attention to the health and nutrition of children is the most urgent first step in fostering normal emotional development; but that alone is not enough.

Developing countries often lack financial resources and thus find it difficult to care for the health needs of their children. It is therefore imperative that suggestions be financially realistic. It is particularly important for countries to concentrate on areas that affect large numbers of children in important ways and to select programmes that are effective in their own cultures. For this reason, the Committee's recommendations, set out in italics in the following sections, are limited to programmes that have been shown to be effective wherever evaluated. In adapting programmes to their own cultures, countries should routinely monitor their acceptability and effectiveness among their own children and families.

2. RECOMMENDATIONS ON THE PREVENTION OF CHILDHOOD MENTAL DISORDER AND THE FOSTERING OF HEALTHY PSYCHOSOCIAL DEVELOPMENT

(1) *Governments are urged to foster the improvement of the general health of children by extending maternal and child care services ; raising nutritional standards ; providing immunization against diseases such as rubella, measles, poliomyelitis, and whooping-cough ; improving housing and school safety standards ; improving sanitary facilities ; and offering habilitation and rehabilitation to the handicapped.* There is ample evidence that prematurity, complications of pregnancy and birth, malnutrition, neurological complications of infection and accident, and physical handicap are associated with increased mental and emotional disorder in children. Thus improvement in general health will improve the mental health of children and conversely.

(2) *Health education programmes for all those having responsibility for the welfare of children should include information on the normal developmental stages of childhood and methods of encouraging healthy psychosocial growth.* Such information can be disseminated through the mass media and included in training programmes and school curricula. Mothers can be reached at prenatal clinics, in well-baby clinics, and when their children are hospitalized or first enrolled at school. Schools should act as settings for encouraging the optimal development of children's personalities as well as places where skills and knowledge are taught.

(3) *Where day-care centres and nursery schools exist they should be staffed by personnel who are informed about the psychosocial development of young children. There should be sufficient personnel, space, and facilities to allow staff to interact with the child in ways that enhance his psychosocial development.*

(4) *Governments should ensure that children have continuity of parent-figures (a) by providing whatever support (including financial) is possible in order to keep families intact, (b) by encouraging the early adoption of children who cannot be looked after by their parents, and (c) by providing continuity of foster parents where substitutes for natural parents are required.* Frequent changes of parent-figures are associated with maladjustment in children.

(5) *When institutionalization of children is necessary, the institutions should provide continuity of staff to care for the children and adequate*

opportunities for play, learning, and personal interaction. Ideally the institutions should be of small size and located in the community.

(6) *When children are admitted to hospital, parents should have unlimited access, there should be individual allocation of nursing staff to children, and, as far as young children are concerned, there should be facilities for admitting the mothers as well.*

(7) *Governments are urged to help parents avoid unwanted children by providing family planning as part of a community-based comprehensive health service.*

(8) *The effectiveness of the preventive programmes suggested should be monitored.* Monitoring may be carried out in several ways : by repeated evaluation of the number of children reported as showing emotional disturbance ; by counting the frequency of children's admissions to institutions ; and by assessing the knowledge about child development acquired by public and health-care personnel.

3. RECOMMENDATIONS ON THE TREATMENT OF MENTAL DISORDERS IN CHILDREN

(1) *Mental health treatment services for children should emphasize the use of health workers already providing population coverage and of volunteer workers. The use of such professionals as social workers, police and probation officers, psychologists, nurses, family doctors, paediatricians, and teachers to provide treatment services should also be encouraged.* It has been shown that with limited training and adequate supervision, many kinds of persons can effectively provide mental health services to children. The categories of persons suggested are already providing other services to children and their families, and broadening their abilities will improve mental health care at a minimum cost and with least disturbance of traditional practices. In this regard, it is important to provide services in such a way as to utilize and increase parental coping skills.

(2) *Countries should emphasize the development of treatment resources at the community level so that most children with mental disorders can receive treatment quickly and in their own home and school environment.*

(3) *An adequate system of referral and support should be developed in order to provide services for children whose problems cannot be handled at the local level.* Under this system, provision would be made for the

training of personnel and the supervision of treatment in the local community.

(4) *Personnel should be instructed in treatment procedures that have been found to be effective in well controlled studies and that make best use of possibly scarce resources.* The child mental health worker should be able to make appropriate use of brief focused counselling, behaviour modification methods, and psychoactive drugs. In the absence of specific indications, the Committee does not recommend for children long-term intensive psychotherapy, prolonged hospitalization, or the long-term use of neuroleptic drugs since these methods have been found to offer no advantage over briefer techniques.

(5) *Continuing evaluation should be carried out of the effectiveness of the mental health services in reaching the children who require them and of their efficacy.* Most of the recommended treatment methods have been evaluated in only one or a few cultural settings. It is essential to know whether they are equally acceptable and effective in other sociocultural settings.

4. RECOMMENDATIONS ON THE DEVELOPMENT OF KNOWLEDGE CONCERNING THE MAGNITUDE, NATURE, AND CAUSES OF MENTAL HEALTH PROBLEMS IN CHILDREN IN VARIOUS COUNTRIES

(1) *Governments not yet doing so should make provision for the collection of reliable, simple data on births and children's deaths by age and cause, as well as statistics on personnel and facilities providing services relevant to children's mental health.*[1] The count of facilities should include schools, health-care facilities, institutions for the retarded, orphanages, nursery schools, and day-care centres. Where possible these figures should be complemented by an account of the services provided and their costs. Such statistics can provide indicators of the level of child mental health facilities available and can provide estimates of the proportion of the budget being spent on children and their needs.

(2) *Governments are urged to acquire information about the distribution of child mental disorders within the country.* Epidemiological investigations of mental disorders in children have been carried out in only a

[1] KRAMER, M. *Applications of mental health statistics.* Geneva, World Health Organization, 1969.

few settings. They have revealed important correlations that form the basis for preventive efforts, but it is not known whether these findings can be generalized to other cultures. To inform the government of the most promising avenues of prevention, it is important to learn how childhood mental disorder is correlated with social factors such as disrupted homes, recent migration, overcrowded homes, poor nutrition, and poverty.

(3) *Studies should be carried out on the effects of social change on the rates and kinds of mental disorders in children.* Rapid changes in social conditions as a result of industrialization, compulsory schooling, resettlement, etc., provide opportunities to examine how these social changes affect children's mental health.

(4) *In order to increase the effectiveness of preventive programmes, governments should encourage studies on the factors that ameliorate mental disorders in children and on those that promote positive psychosocial development.* Conditions in which children are exposed to multiple stresses, diseases, psychosocial change, and the disappearance of traditional community support structures are particularly suitable for such studies. Similarly, studies can be conducted to identify the types of institutions that provide the most effective help.

5. RECOMMENDATIONS ON THE PLANNING AND COORDINATION OF PROGRAMMES

All activities of governments that impinge on a child's life have implications for his wellbeing. A policy based on a holistic view, which recognizes the interactions between mental health and physical health, has the greatest hope of producing beneficial results.

(1) *Each country should formulate and adopt a national policy for child mental health emphasizing intersectoral coordination among all the departments of government that have an impact on the psychosocial development of children (especially health, justice, education, and social welfare) and the coordination of these government departments with the appropriate nongovernmental bodies.*

(2) *Each country should establish or designate a coordinating group at the national level responsible for reviewing the whole range of national policies and the degree to which children's needs are being met, for monitoring the implementation of programmes relevant to children, and for making recommendations for alterations in policy.* The evaluation of programmes

67

should include an assessment of service coverage. Professional and voluntary bodies should have direct access to this group. Groups with comparable responsibilities should also be designated by regional and local governments and should coordinate and monitor services at that level. Such groups could be helpful in the definition and application of criteria for the selection of priority programmes. These criteria may include the frequency and severity of disorders, the feasibility and likelihood of success of interventions, community interest, and considerations of local importance to the country concerned.

6. RECOMMENDATIONS ON THE TRAINING OF CHILD MENTAL HEALTH PERSONNEL

(1) *Where they do not already exist, research and training centres should be established for the study of child mental health and the treatment of mental disorders.* The staff of such centres should be multidisciplinary. In addition to their treatment and research functions, the centres should provide resources for training all types of health workers concerned with child mental health—for example, medical students, physicians, teachers, and police officers. The educational resources they provide should include materials for use away from the centres, e.g., correspondence courses and information for the mass media. In addition, the staff of the centres should provide consultation services to other treatment and training groups.

Whether at the national centre or elsewhere, those skilled in child mental health should train a wide range of health workers, ranging from the psychiatric specialist to the village worker. Those already working with children should be given a better understanding of normal psychosocial development, which would help them to recognize indications for referral. The effectiveness of the training programme should be monitored by evaluating the number of persons trained, the degree to which they continue to work in child mental health, and the proportion of them developing into trainers of others.

7. WHO'S ROLE IN PROGRAMMES CONCERNED WITH CHILD MENTAL HEALTH AND PSYCHOSOCIAL DEVELOPMENT

The basic functions of WHO are cooperation with countries in the resolution of their health problems and transfer of information. The

Organization endeavours to ensure that relevant information reaches the decision-makers and others concerned with health with the minimum delay. These efforts are undertaken bearing in mind the overwhelming need for countries to achieve self-reliance in matters concerning the health of their populations.

7.1 Technical cooperation with countries

(1) *The Committee recommends that WHO cooperate with countries in the development of programmes leading to an amelioration of child mental health and psychosocial development. It endorses the relevant recommendations made by the WHO Expert Committee on Mental Health in its sixteenth report,*[1] *in particular recommendations 5, 9, 11 and 15, and the recommendations of the WHO Expert Committee on Maternal and Child Health in its sixth report.*[2]

In this process WHO can work with countries in the formulation of national health policies, which will include provisions for the promotion of child health and the prevention and treatment of mental disorders and which will provide the basis for appropriate legislative measures.

(2) *WHO should cooperate with countries in their efforts to develop the personnel necessary for programme implementation.* The promotion of psychosocial development and the provision of care for the disturbed child require collaboration between health service staff, the personnel in other services, the parents, and the community. Training and education should not therefore be restricted to the production of mental health specialists : other categories of health personnel should rather be the focus of training efforts. Similarly, training should be provided to teachers, members of the judiciary, traditional health practitioners (e.g., the traditional birth attendant) and others who are likely to be in a position to offer help to disturbed children, prevent the occurrence of disorders, and promote psychosocial development. Development of guidelines and manuals for different categories of personnel and the

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[1] WHO Technical Report Series, No. 564, 1975 (*Organization of mental health services in developing countries*). Recommendations 5, 9, 11, and 15 called for the decentralization of mental health services and their integration with the general health service, the carrying out of basic mental health care by all health workers, the preparation of mental health professionals for the task of training and supporting nonspecialized health workers, and the collection of basic statistics for evaluating the progress of mental health programmes.

[2] WHO Technical Report Series, No. 600, 1976 (*New trends and approaches in the delivery of maternal and child care in health services*).

search for an improved training technology may be particularly relevant in this respect.

Education of the community and of parents is an equally important function in which WHO could assist countries. In all these efforts the use of well established WHO mechanisms (e.g., the fellowships programme, exchange of research workers, short training courses) will have to be matched with innovative training programmes adapted to country needs and resources.

The development of new training technologies and models of service provision and the carrying out of research on other priority issues require a country-based structure closely linked to the health administration and educational authorities.

(3) *WHO should collaborate with countries in the establishment of research and training centres on matters concerning child mental health and psychosocial development.* These centres can serve as focal points for the coordination of efforts made by different types of service and can assist in achieving intersectoral collaboration at the level of service provision. In this way it may become easier to incorporate mental health components in the work of other health personnel, particularly those concerned with maternal and child health at the primary care level.

(4) *WHO should promote the incorporation of mental health components in the work of various departments and services concerned with children.*

7.2 Transfer of information

Measures that countries undertake to improve child health can be facilitated if relevant information is available to decision-makers, health workers, and the staff in other sectors for programme planning and implementation. To obtain such information, effective mechanisms have to be created at the country level. These mechanisms would include adequate recording and reporting of the services provided by different agencies to improve child health and the availability of personnel trained in the interpretation of data and the development of simple methods of data presentation. At the international level, the exchange of information and the ability to learn from the experience of others are essential.

(1) *WHO should continue its development work on a commonly acceptable and applicable classification of mental conditions in children and intensify its efforts to develop health and social indicators and methods that will facilitate international comparisons and collaboration.* While

these efforts are likely to improve the exchange and utilization of available information, they do not obviate the need for studies directed to the acquisition of necessary new knowledge.

(2) *WHO should stimulate and coordinate research in areas identified as priorities by countries and likely to contribute to knowledge necessary to implement programmes at country, regional, and international level. Such research should have the capacity of enhancing or creating country self-reliance in research.* Results of research carried out in different parts of the world, as well as experiences of different countries, can be of direct use to Member States.

(3) *WHO should develop mechanisms that will ensure the application of available knowledge at country level without delay. These may include the establishment of an interdisciplinary standing advisory committee on child mental health and psychosocial development, which would assist WHO in its programmes of technical cooperation and transfer of information.*

7.3 Coordination with international agencies

Numerous intergovernmental and nongovernmental organizations, voluntary agencies, and other bodies are undertaking activities to improve child health. Their efforts are often independent rather than synergistic, and scarce resources are therefore used in suboptimal ways.

(1) *The Committee recommends that WHO strengthen collaboration with United Nations agencies and intergovernmental organizations concerned with child health, particularly ILO, UNESCO, UNHCR, and UNICEF, as well as the International Children's Centre.*

(2) *WHO should also establish or strengthen collaboration with nongovernmental organizations active in this field, particularly the International Association for Child Psychiatry and Allied Professions, the Joint Commission on International Aspects of Mental Retardation, the World Federation for Mental Health, and the World Psychiatric Association. Where appropriate, WHO should help nongovernmental organizations to increase their coordinating role in this field.*

8. CONCLUSION

In this report the Expert Committee has drawn attention to the importance of ensuring healthy psychosocial development and the preven-

tion and treatment of mental health problems in children and has stressed the inadequacy of existing services in most countries.

The Committee concluded that a vast amount of knowledge at present remains unused, and that its application might substantially improve the fate of children. Action should be directed to the promotion of mental development and health in children because this would lead to overall development. Such action would not require vast resources but mainly the reorientation and coordination of activities undertaken by various sectors of community services and by the community as a whole.

Areas where new knowledge is necessary have been identified and ways suggested of obtaining it. It has, however, been clearly recognized that awaiting results of research should not be an excuse for inaction.

The detailed recommendations in the report have been made with full awareness of the desperate problems of hunger, communicable diseases, and poverty that exist in large parts of the world and of the fact that the resolution of these problems would inevitably and decisively improve the psychosocial conditions in which human beings grow up. However, action as outlined in this report must be taken now if the rights and wellbeing of the world's children are to be preserved.

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